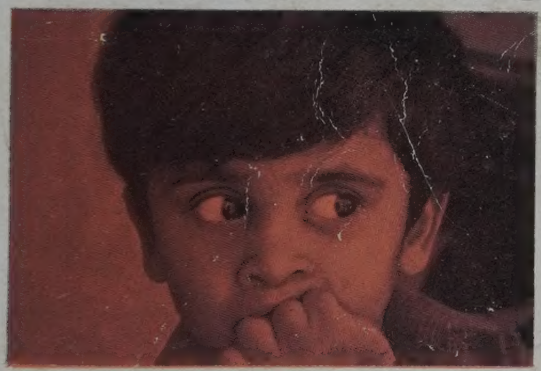
perspectives on the child in india



CENTRAL INSTITUTE OF RESEARCH &
TRAINING IN PUBLIC COOPERATION

PERSPECTIVES ON THE CHILD IN INDIA

CENTRAL INSTITUTE OF RESEARCH &
TRAINING IN PUBLIC COOPERATION

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FOREWORD

Efforts to improve the well-being of children reflect not only a humanitarian concern for the deprived and the handicapped, but also for the positive contribution all young people must make in the future economic and social development of the country. It is now widely recognised that children are to be viewed not merely as objects to be protected by appropriate social policies and welfare services but also as seedlings of future human resources, who must be carefully nursed and nurtured so that in time, they are able to contribute to the country's development efforts. Moreover, programmes for children are an important instrument of social justice, providing children of poor families with the nutrition, health care, education and welfare services they need in order to compete on more equal terms with children of well-to-do families. By affecting income distribution, these programmes help to reduce inequality of opportunity between the rich and the poor.

This reasoning and philosophy have formed the basis for adopting a momentus and much-awaited Resolution on *National Policy for Children* by the Government of India in August 1974. The resolution recognises children as the nation's "supremely important asset" and declares that the nation is responsible for their "nurture and solicitude". It further spells out the various measures to be adopted and priority to be assigned to children's programmes with a focus on certain defined areas. The Resolution, *inter alia*, provides for the constitution of a National Board for Children under the Chairmanship of the Prime Minister. The Board will have advisory and coordinating roles to perform in relation to programmes for children in the country.

The same emphasis is reflected in the Fifth Plan approach where the major thrust of the Social Welfare Sector is on the

expansion of preventive and developmental programmes for children by launching the Integrated Child Development Scheme (ICDS). The package of services to be provided through the ICDS will lay emphasis on supplementary nutrition, immunisation, health check-up, referral, nutrition and health education. The programme is expected to be implemented in about 1000 rural and tribal community development blocks and urban slum areas during the Fifth Plan period.

A 'National Centre for Child Development' has been set up by reorganising and strengthening the Central Institute of Research and Training in Public Cooperation, which will shortly be renamed as the National Institute of Public Cooperation and Child Development. The Institute will function as a training, research, documentation and analysis base for policies and programmes affecting young children in the country. In persuance of these functional responsibilities, one of the projects undertaken by the Institute was that of compilation of a source-book on the child in India. The need for such a source-book has been keenly felt by all those concerned with child welfare in India as the relevant data on child were scattered and fragmentary. The present book is modestly designed to meet this need. With its coverage of children of 0–14 age group, the book, in a way, supplements another excellent work, The Young Child-Indian Case Study, by the UNICEF-SCARO, covering children of 0–6 age group and to be published shortly by the Institute.

The book begins with a demographic profile of the child in India and proceeds to discuss the present status of the child in terms of health, nutrition, education and general welfare; analyses the Government of India's response to the problem; reviews the progress in meeting the problem; and concludes with a futuristic perspective. It was not the intention here, nor was it feasible in a document of this type, to cover comprehensively all aspects of child development. Rather, our hope is that the document will help the reader gain a better understanding of this complex and diversified problem by highlighting its selective aspects and prepare the ground for a more comprehensive work in this area.

The book is divided into six chapters and contains 45 tables, drawn and adapted from various sources. It also contains 25 charts to lighten the text and to make various points more vividly than words can do. The audience for this source-book, will presumably be planners and administrators in governmental units, and in sectoral ministries, research and training institutions, professional groups and non-governmental organisations concerned with various aspects of child development. It is hoped that the book would be found useful by them.

The publication of this work has been hastened to meet the deadline to make available copies for the UNICEF Board Meeting in New York in May 1975. As such it is not unlikely that certain errors or ommissions might have inadvertently crept in. These, if any, will be weeded out in the subsequent edition of the publication.

I would like to record my appreciation of the labour put in by Dr. Subhash Chandra, Specialist at the Institute, who was in-charge of the project and mainly responsible for the preparation of this report. He was ably assisted, in this task, by a team of Research Assistants consisting of Km. Amulya Satpathy, Shri N. R. Moorty and Shri M. S. Yadav.

I would like to thank Shri P. N. Luthra, Secretary, Government of India, Department of Social Welfare, for the trust and confidence reposed in the Institute and encouraging us to play a meaningful role in the very critical area of child development; and to Shri M. S. Dayal, Deputy Secretary, for taking immense pains to go through the volume critically and clearing it expeditiously for publication. Our sincere thanks are also due to Shri S. J. Dubey, Manager, Delhi University Press, for taking up the job at a short notice and completing it excellently in a record time of ten days.

New Delhi
May 8, 1975

B. CHATTERJEE
Director

ACKNOWLEDGEMENTS

I would like to acknolwedge with gratitude the help and guidance given to me in the preparation of this book by Mr. B. Chatterjee, Director, and Mr. R. G. Srivastava, Deputy Director of the Central Institute. I would also like to thank Mr. N. R. Moorthy and Miss Amulya Satpathy, Research Assistants of the Institute, for their contribution in compiling material for this publication. The charts, initially drawn by Mr. Moorthy and Mr. M. S. Yadav, were finally shaped by Mr. K. C. Bhalla of the Delhi University. Their help is much appreciated. Thanks are also due to Mr. V. D. Kaura, Research Associate, Mr. S. S. Dadhich, Administrative Officer and other members of the Institute's Faculty and Staff for their help and assistance. I would also like to thank Mr. S. J. Dubey, Manager, Delhi University Press and his hard-working team for printing the book at a very short notice.

SUBHASH CHANDRA

"Our century is called the century of nuclear power and air and space travel. This is true of course, but I would prefer to call it the century of the child".

— Indira Gandhi

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CHAPTER I

A Demographic Profile of the Child in India

"To plan when population growth is unchecked is like building a house when the ground is constantly flooded. Family planning is an essential part of our strategy of enlarging welfare. Greater welfare is in fact the only reason for family planning, and we need it, not because we are against more children, but because we want every child to have the best opportunity possible in life".

—Indira Gandhi

A demographic profile of the Child in India may well begin with a statement of some broad demographic features of the Indian population.

Population Growth

In the world today, India ranks *second* in population numbers (Communist China tops the list with more than 750 million people) and *seventh* in the land area. That is, with only 2.4 per cent of the world's total land area, India has to support 14 per cent of the world's total population.

India's population began to increase rapidly only during the last half a century. The year 1921 proved to be a great divide in the history of India's population (Chart I). From 1921, the fertility and mortality pattern began to vary considerably. With the advent of economic development and relative improvement in medical facilities, mortality rates began to register a steady decline. In a sense, after 1921 India's population became quasi-stable with a declining mortality and a stationary or slowly declining fertility, resulting in an ever-increasing demographic gap.

In brief, India's population increased from 236 million in 1891 to 251 million in 1921, only a 15 million increase in 30 years because of famines, epidemics, and the world-wide influenza epidemic of 1918-19. But during the next 20 years, the numbers increased by 110 million and during the succeeding decade 1951-61 by 78.1 million. During the last decade 1961-71, the population registered a growth rate of 24.8 per cent and a net addition of 108 million—the highest experienced in any decade. This net addition of 108 million persons should be viewed in the light of the fact that Japan's total population is 103 million.

The main reason for the rapid increase in India's population is a decline in the death rate and not an increase in the birth rate. Chart 2, for instance, shows that the birth rate, which was around 47 in 1921 and 41 in 1961, has come down to 39 in 1971. But the death rate which was around 36 in 1921, and 22 in 1961, has come down to 14 in 1971—a decline by more than one third in a ten-year period.

India has a young population, for according to the 1971 Census, 42 per cent of the total population of 547 million people was in 0–14 age group. As the rural urban ratio was 80:20, out of 230 million children in India, about 188 million lived in rural areas. There were about 115 million children in the age group 0-6 years, constituting about one-fifth of the total population (Chart–3). While distribution of the young child population by rural, tribal and urban areas is not available, it has been estimated that in the 0–6 year age group there were 6.9 million in tribal areas, 85.1 million in rural areas and 23.0 million in urban areas in the year 1971.[1]

Thus, young and more fecund people predominate the population composition creating an unfavourable age-structure (Chart –4) with a large proportion of juvenile population, resulting in a high dependency ratio. Because of this low ratio of adults to children, India's labour force has been

increasing at a slower rate as compared to total population increase.

Mortality

India's present overall crude death rate stands at about 14 per thousand (Table : 1). It does not compare very well with other neighbouring countries as Sri Lanka, Malaysia, or Taiwan, all of which have mortality rates less than one-half that of India. Nevertheless, it represents an extraordinary improvement over the past (48 per thousand in 1920).

However, this mortality rate is distributed quite unevenly in India. People in the extreme North (Punjab) and the extreme South (Kerala) live longer, having crude death rate of 12 and 9 per thousand, respectively. At the other end are U.P. and Rajasthan, with mortality rates of about 24 to 20 per thousand, respectively.[2]

Similarly, the death rate in rural India is around 17 per thousand, while in urban India, it is around 10 per thousand.[3] This means that the average child born in an Indian city or town can look forward to living about 60 years, compared with 47 years for his rural counterpart. The limited number of local health surveys available all indicate that lower socio-economic groups suffer from mortality rates one and one-half to two times as high as those of their more privileged counterparts.[4]

While the crude death rate has fallen by more than two thirds over past fifty years, i.e. from 48 per thousand in 1911-21 to around 14 per thousand now, the infant mortality rate has registered far less dramatic improvement and it fell by only one-half as much during this time, from 220 to just under 140.[5] As a result, the differential between infant and adult mortality is now significantly greater than it has been in the past.

In India, young children remain the most vulnerable group in the population with 40 per cent of all deaths occuring in the 0-5

age-group. Nearly 14 per cent or one-seventh of Indian children die before they reach their first birthday. In India a baby is born every second and a half, or 21 million births a year and some eight million persons die every year. Of these deaths more than two million are below the age of one year (Chart–5). That is, about a hundred infant deaths occur for a thousand live births in a year.

There are substantial gaps in precise knowledge of the causes of child mortality, as most of the events are non-institutionalised or are not attended by any recognised doctor. According to Prof. Chandrashekhar, neo-natal deaths (those within one month of birth) are primarily due to pre-natal and natal influences such as immaturity, birth injuries, conjenital malformations etc. Table : 9 gives a rough picture of the causes of child mortality.

Child Morbidity

Morbidity data available for the country at present are very scant. In India, no general health survey has been carried out so far at the national level. The limited number of local health surveys available all indicate a high morbidity rate among children. Though malaria has been almost eradicated, small pox brought under control. and several other major killer diseases made non-consequential, serious, if not fatal diseases still strike the young child hard. It is estimated that 75 per cent of the child population can be classified as 'not healthy' due to major and minor illnesses.

Environmental sanitation is considered vital for child survival. High morbidity rate among children is largely attributed to unfavourable and insanitory environmental conditions, obtaining particularly in urban slums and villages. Many infections in childhood like diarrhoea, dysentry, cholera, typhoid and hepatitis are caused by ingesting infected food. Children of the age-group 0–5 are the primary victims of these infections.

Weaning is another critical period in the life of Indian children. About 56 per cent of illnesses treated in health centres are related to intestinal infections, respiratory complaints(complicated by malnutrition) and nutritional disorders of various types. Even where death or disablement does not result, it is obvious that enormous human suffering is entailed, besides the loss in growth, health and efficiency and sheer wastage of human resources.

On the other hand, children who survive the first month of life but die before they complete one year, usually succumb to post-natal influences such as the various epidemic diseases, diseases of respiratory system, faulty feeding and the environmental factors. Thus, deaths in the second to twelfth month are largely attributable to preventable causes, i.e. factors associated with nutrition, environmental conditions and domestic sanitation.[6]

A perusal of the infant mortality trends during the last seventy years in our country and in certain selected countries of the world (Tables: 7 & 8) reveals, on the one hand, the phenomenal progress made in these countries in ensuring infant survival and welfare, and on the other hand, India's unenviable position. Though, a child born in India today has a better chance of surviving infancy and childhood than a child born 20 years ago, and there has been a steady though slow increase in the life expectancy during the successive decades since 1901, and accelerated increase during 1951-60 (Chart-6), the fact cannot be glossed over that India even today has an infant mortality rate not less than 5 to 6 times that obtaining in the advanced countries of the world.

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2. Government of India, Ministry of Home Affairs, Office of the Registrar General, Vital Statistics Division, *Sample Registration of Birth and Deaths in India*, 1969-70, April 1972, p. 22.

3. *Ibid*, p. 22.

4. Vaidyanathan cites Lucknow Survey as showing infant mortality rates of 59 among high caste Hindus, compared with 136 among low-caste Hindus. K. E. Vaidyanathan, *Some Indices of Differential Mortality in India*, Gandhigram Institute of Rural Health & Family Planning, pp. 59-158.

5. Government of India, *Registrar General and Census Commission, Pocket Book of Population Statistics, India*, New Delhi, 1972, p. 96.

6. *SRS Bulletin*, Vol. VI No. 3 & 4, July-December 1972, Registrar General of India, Government of India.

Chart : 1

Population Growth 1901-1971

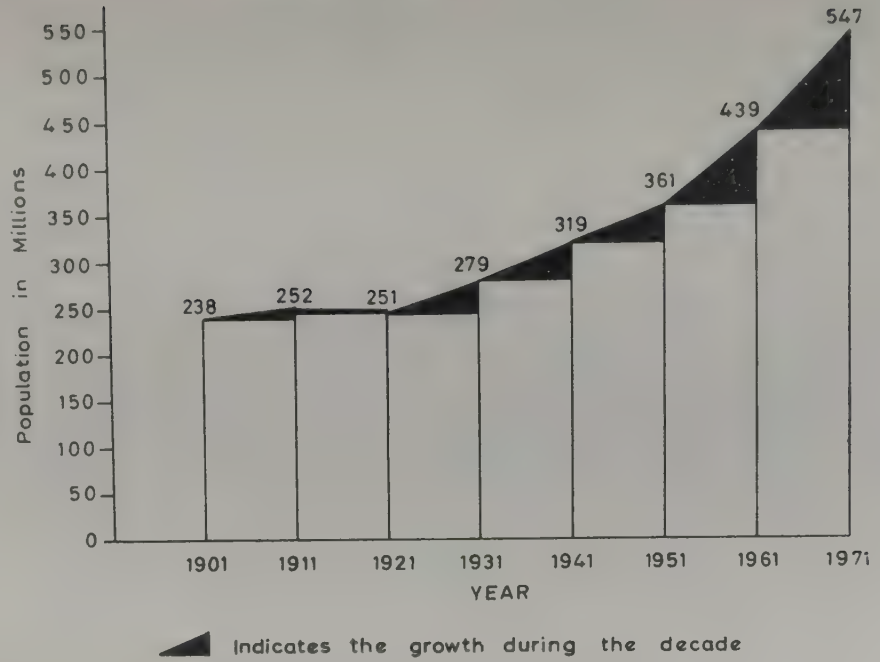

Chart : 2

Estimated Birth, Death and Growth Rates per Mille(1921-1970)

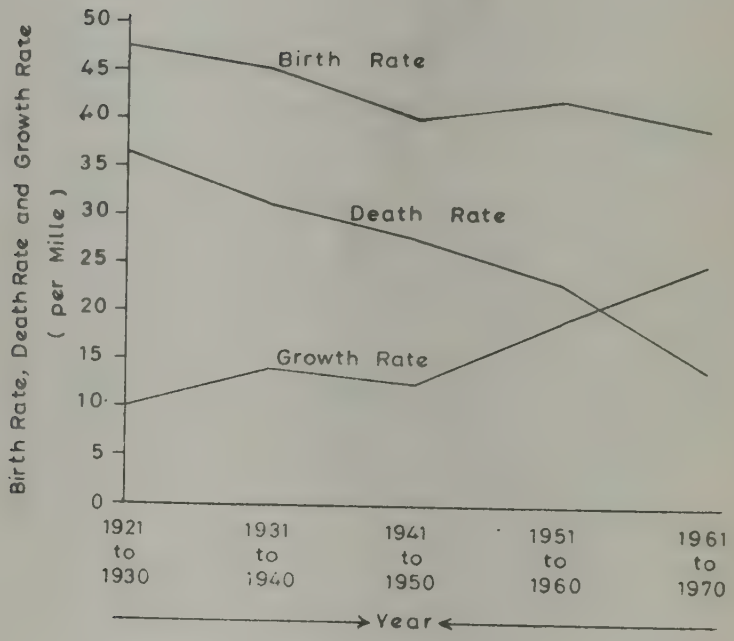

Chart : 3

Age Structure of Child population - India - 1971
(0-14 Years)

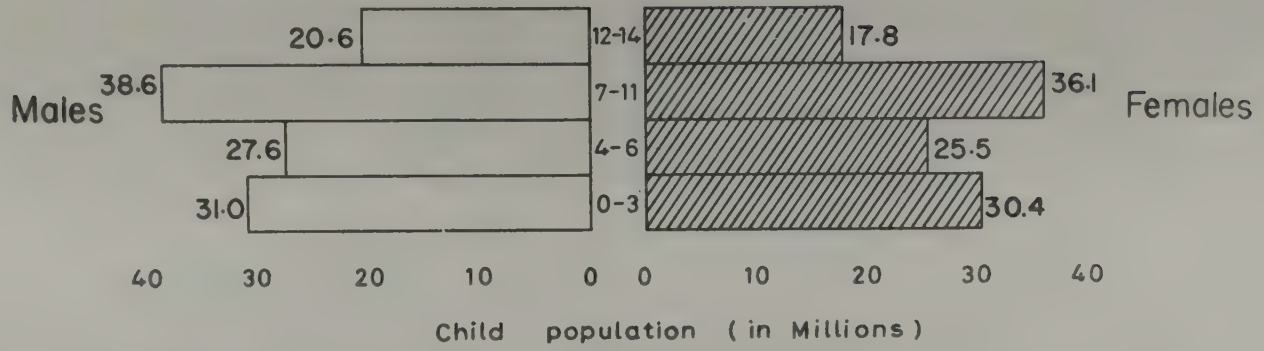

Chart : 4

Age Structure 1971

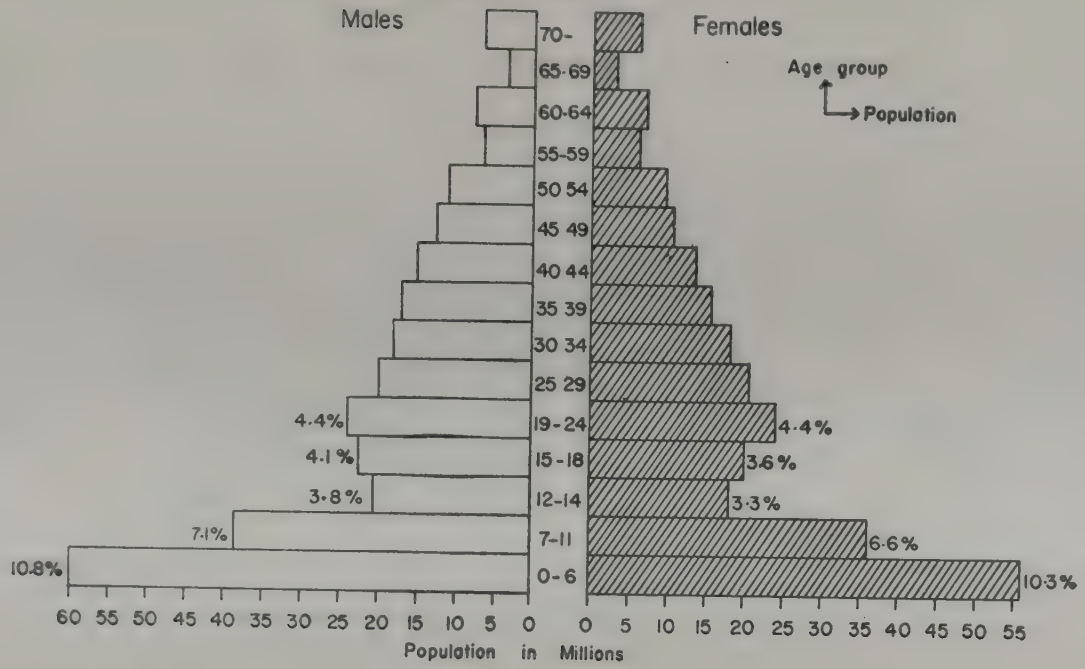

Chart: 5

Infant Mortality and its Component by Sex: Rural, 1969

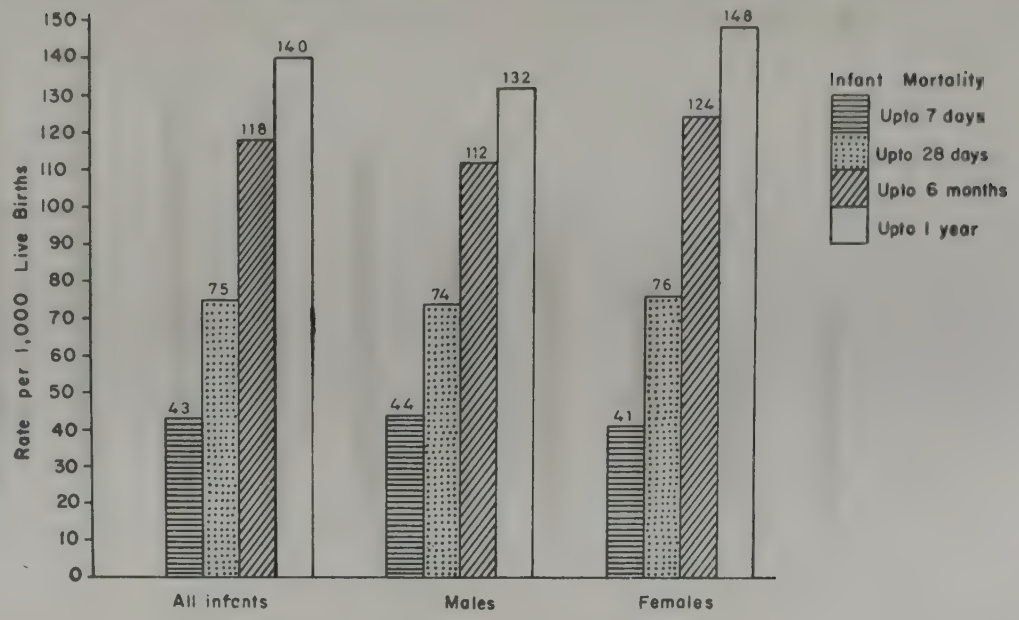

Chart : 6

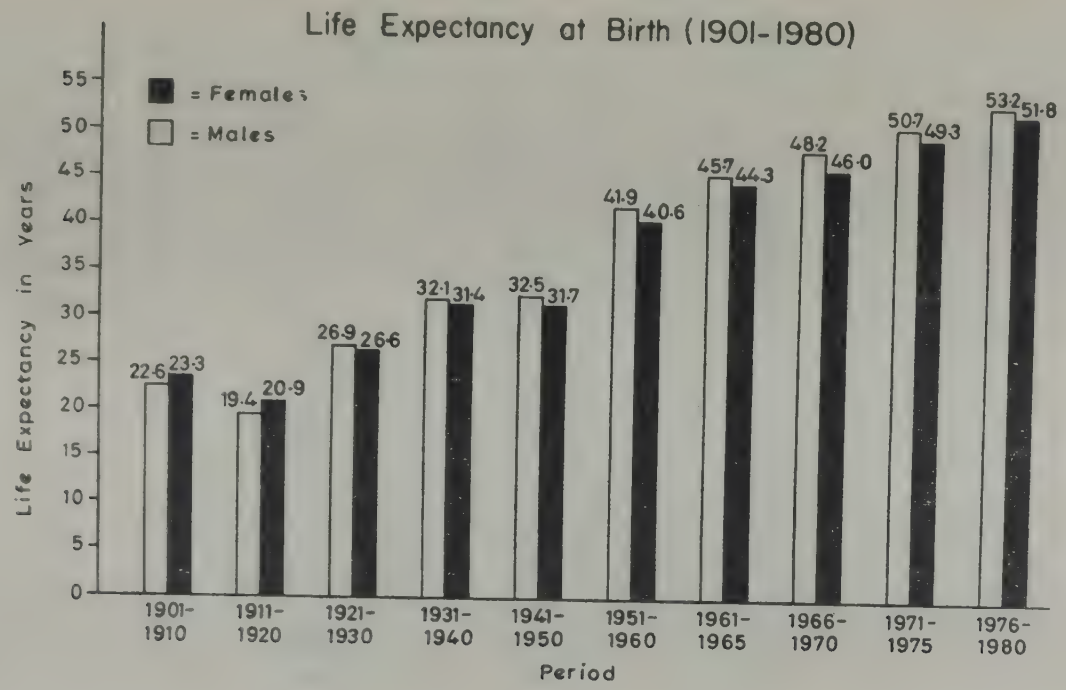
Life Expectancy at Birth (1901-1980)
= Females
= Males
Life Expectancy in Years
0
5
10
15
20
25
30
35
40
45
50
55
22·6
23·3
19·4
20·9
26·9
26·6
32·1
31·4
32·5
31·7
41·9
40·6
45·7
44·3
48·2
46·0
50·7
49·3
53·2
51·8
1901-1910
1911-1920
1921-1930
1931-1940
1941-1950
1951-1960
1961-1965
1966-1970
1971-1975
1976-1980
Period

TABLE 1

Estimated Birth Rates and Death Rates (1901–70) in India

Year	Birth Rate (per Mille)	Death Rate (per Mille)	Growth Rate (per Mille)
1901-1910	48.1	42.6	5.5
1911-1920	49.2	48.6	0.6
1921-1930	46.4	36.3	10.1
1931-1940	45.2	31.2	14.0
1941-1950	39.9	27.4	12.5
1951-1960	41.7	22.8	18.9
1961-1970	39.0	14.0	25.0

Source: Family Planning In India—Programme Information 1971-72; Govt. of India, Ministry of Health & Family Planning.

TABLE 2

Life Expectancy (1901–1980)

Year	Expectancy of Life at Birth	
	Males	Females
*1901–1910	22.6	23.3
*1911–1920	19.4	20.9
*1921–1930	26.9	26.6
*1931–1940	32.1	31.4
*1941–1950	32.5	31.7
*1951–1960	41.9	40.6
**1961–1965	45.7	44.3
**1966–1970	48.2	46.0
**1971–1975	50.7	49.3
**1976–1980	53.2	51.8

*Census of India, Paper No. 1 of 1962, 1961 Census.

**Revised population Projections in the light of 1971 Census.

Source: Census of India, 1971, Registrar General's Office, Government of India.

TABLE 3

Age Stucture–1971 (In millions)

Age Group	Sex		Age Group	Sex	
	Males	Females		Males	Females
0–6	58.8	55.9	40–44	15.0	13.3
7–11	38.7	36.1	45–49	12.4	10.4
12–14	20.6	17.9	50–54	11.1	9.4
15–18	22.4	19.8	55–59	6.7	5.8
19–24	24.2	24.0	60–64	7.4	6.8
25–29	20.0	20.5	65–69	3.5	3.2
30–34	18.1	17.9	70+	6.3	6.1
35–39	17.1	15.7			

Estimated from 1% sample data,
Source: Census of India 1971, Part-II Special, Registrar Generals Office.

TABLE 4

Population Projections (In Millions) 1972–1981

Year	Sex		Total	Year	Sex		Total
	Males	Females			Males	Females	
1972	288.8	269.2	558.0	1977	318.9	297.0	615.9
1973	294.9	274.8	569.7	1978	324.5	302.1	626.6
1974	301.0	280.5	581.5	1979	329.9	307.1	637.0
1975	307.2	286.1	593.3	1980	335.3	312.0	647.3
1976	313.3	291.7	605.0	1981	340.5	316.9	657.4

Source: Expert Committee on population Projection—Revised Estimates after 1971 Census, Provisional Totals 1972.

TABLE 5

Percentage Distribution of Children & Youth–India 1971

Age Group	Sex		Total
	Males	Females	
0–6	10.8	10.3	21.1
7–11	7.1	6.6	13.7
12–14	3.8	3.3	7.1
15–18	4.1	3.6	7.7
19–24	4.4	4.4	8.8
Total (024)	30.2	28.2	48.4

Estimated from 1% Sample Data.
Source: Census of India 1971, Registrar General's Office.

TABLE 6

Infant Mortality, Neo-Natal Mortality, Post-Natal Mortality-NSS, 19th Round, July 1964—June 1965

Mortality	Rural			Urban		
	Males	Females	Combined	Males	Females	Combined
Neo-Natal	68.98	57.64	63.49	53.08	35.40	44.56
Post-Natal	49.63	52.49	51.01	35.65	35.07	35.37
Infant	118.61	110.13	114.50	88.73	70.47	79.93

Definition:

(1) *Infant Mortality:* Number of deaths under one year of age in a year per 1000 live births of the same year.

(2)*Neo-Natal Mortality*: Number of deaths under one month of age per 1000 live births of the same year.

(3) P*ost Natal Mortality*: Number of deaths under one year but over one month of age per 1000 live births of the same year.

Source: Infant Mortality in India, SRS Analytical Series No. 1, 1971, Registrar General's Office, India.

TABLE 7

Infant Mortality Rates In Selected Countries, 1965

Country	Infant Mortality Rate/1000	Country	Infant Mortality Rate/1000
India	101	New Zealand	20
Portugal	65	Japan	10
Spain	37	Australia	19
U.S.A.	25	England & Wales	19
France	22	Sweden	12

Source : Infant Mortality, Population Growth and Family Planning in India by S. Chandrasekhar.

TABLE 8

Registered Birth Rates and Infant Mortality Rates In India (1901–1970)

Year	Birth Rate per mille	Infant Mortality per mille
1901	34.6	202
1911	38.6	205
1921	32.0	198
1931	34.3	179
1941	32.1	158
1951	24.9	123
1961	23.1	83
1966	41.0	113*
1970	39.0	113*

*Average of five years.

Source : Infant Mortality, Population Growth and Family Planning in India— S. Chandrasekhar.

TABLE 9

Percentage Distribution of Deaths, Age & Sex—1969

Age Group in years Cause and/or Prominent symptoms	0–1		1–4		5–14	
	Male	Females	Males	Females	Males	Females
Violence or Injury	0.3	0.5	1.7	1.4	12.5	6.7
Diarrhoea	7.0	7.3	17.4	16.9	16.0	16.5
Cough	19.1	18.2	26.2	26.4	17.7	19.1
Swellings	0.9	1.1	4.5	4.5	6.5	5.4
Fevers	10.6	13.6	36.0	36.0	37.6	42.2
Other Infant Deaths	53.6	50.4	—	—	—	—
Other clear Symptoms	6.7	6.8	3.0	2.1	4.7	2.8
Others	1.8	2.1	10.6	11.7	5.0	7.3
Total	100.0	100.0	100.0	100.0	100.0	100.0
Percentage of Deaths	21.4	21.2	15.3	18.5	6.7	7.2
Per cent Total Deaths		21.3		16.8		6.9

Source: Model Registration, *Report on Survey of Cause of Death 1969,* Vital Statistics Division, Office of the Registrar General, Government of India.

TABLE 10

Percentage Distribution of children (0-14)—India 1971

Age Group	Persons		
	Males	Females	Total
Below 1 Year	1.5	1.5	3.0
1–3	4.2	4.1	8.3
4–6	5.1	4.7	9.8
0–6	10.8	10.3	21.1
7–11	7.1	6.6	13.7
12–14	3.8	3.3	7.1
0–14	21.7	20.2	41.9

Estimated from 1% Sample Data

Source: Census of India, 1971, Registrar General's Office.

TABLE 11—*Child Population (0-14) and Percentage Distribution State-wise— 1971*

(in thousands)

State/Union Territory	Total			Rural			Urban			Percentage of children (0-14) to the total population of India
	Total	Males	Females	Total	Males	Females	Total	Males	Females	
Andhra Pradesh	17,609	8,895	8,714	14,292	7,215	7,077	3,317	1,680	1,637	3.21
Assam	7,010	3,539	3,471	6,479	3,265	3,214	531	274	257	1.28
Bihar	23,994	12,505	11,489	21,713	11,301	10,412	2,281	1,203	1,078	4.38
Gujarat	11,494	5,987	5,507	8,486	4,412	4,074	3,008	1,574	1,434	2.10
Haryana	4,640	2,474	2,166	3,899	2,085	1,814	741	389	352	0.85
Himachal Pradesh	1,426	725	701	1,341	680	661	85	44	41	0.26
Jammu & Kashmir	1,980	1,021	959	1,623	836	787	357	185	172	0.36
Karnataka	12,435	6,252	6,183	9,579	4,805	4,774	2,856	1,447	1,409	2.27
Kerala	8,595	4,345	4,250	7,272	3,674	3,598	1,323	671	652	1.57
Madhya Pradesh	18,203	9,369	8,834	15,354	7,884	7,470	2,849	1,485	1,364	3.32
Maharashtra	20,840	10,659	10,181	14,993	7,644	7,349	5,847	3,015	2,832	3.80
Manipur	456	229	227	401	201	200	55	28	27	0.08
Meghalaya	441	221	220	384	193	191	57	28	29	0.08
Nagaland	196	99	96	181	92	89	15	8	7	0.04
Orissa	9,294	4,668	4,626	8,559	4,291	4,268	735	378	357	1.70
Punjab	5,594	2,977	2,617	4,335	2,312	2,023	1,259	664	595	1.02
Rajasthan	11,381	5,980	5,401	9,448	4,960	4,488	1,933	1,020	913	2.08
Tamil Nadu	15,562	7,862	7,700	10,915	5,915	5,405	4,647	2,351	2,296	2.84
Tripura	688	349	339	624	316	308	64	32	32	0.13
Uttar Pradesh	36,965	19,786	17,179	31,870	17,110	14,760	5,095	2,675	2,420	6.75
West Bengal	19,008	9,654	9,354	15,120	7,627	7,493	3,888	2,027	1,861	3.47
Andaman & Nicobar	44	22	22	35	18	17	8	4	4	0.01
Arunanchal Pradesh	179	91	88	174	88	86	5	3	2	0.03
Chandigarh	89	48	41	9	5	4	80	42	38	0.02
Dadra & Nagar Haveli	34	17	17	34	17	17	—	—	—	0'01
Delhi	1,571	830	741	188	101	87	1,383	729	654	0.29
Goa, Daman & Diu	327	167	160	246	125	121	81	41	40	0.06
Lakshadweep	13	7	6	13	7	6	—	—	—	0.01
Pondicherry	186	94	92	109	55	54	77	39	33	0.03
INDIA	2,30,254	1,18,870	1,11,384	1,87,678	96,832	90,846	42,576	22,038	20,538	42.02

Source: Census of India 1971, Series I, Paper 3 of 1972, Registrar General and Census Commissioner, India.

TABLE 12

Distribution of children (0–14 years)—India 1971

(in thousands)

Age	Total			Rural			Urban			Percentage to the total population in India
	Total	Males	Females	Total	Males	Females	Total	Males	Females	
0–3	61,495	31,092	30,403	50,521	25,493	25,028	10,973	5,598	5,375	11.22
4–6	53,259	27,679	25,580	43,898	22,796	21,102	9,362	4,884	4,478	72
0–6	14,754	58,771	55,983	94,419	48,289	46,130	20,335	10,482	9,853	20.94
7–11	74,813	38,652	36,161	60,839	31,426	29,413	13,974	7,226	6,748	13.65
12–14	38,457	20,626	17,831	30,664	16,479	14,185	7,793	4,147	3,646	7.02
0–14	2,28,024	1,18,049	1,09,975	1,85,922	96,194	89,728	42,102	21,855	20,247	41.61

Note: Estimated from 1 per cent sample data.
Source: Census of India 1971. Series I, Part II Special, Registrar General and Census Commissioner, India.

TABLE 13

Annual Estimates/Projections of Chilldren (0-14 years) by Age and Sex as on Ist March of each year—All India 1972-75

(*in thousands*)

Age	1972			1973			1974			1975		
	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females
0–4	39,106	45,745	43,361	90,053	46,268	43,785	91,010	46,797	44,213	91,973	47,329	44,644
5–9	78,609	40,452	38,157	80,175	41,267	38,908	81,758	42,090	39,668	83,351	42,919	40,432
10–14	69,172	35,297	33,875	70,905	36,275	34,630	72,657	37,263	35,394	74,419	38,257	36,162
0–14	2.36,887	1,21,494	1,15,393	2,41,133	1,23,810	1,17,323	2,45,425	1,26,150	1,19,275	2,49,743	1,28,505	1,21,238

Source: Report on the Population Projections, Office of the Registrar General, India, Ministry of Home Affairs, Government of India.

TABLE 14

Infant Mortality and its component by Sex: Rural

Year	Total Infant mortality	Age of infants (rate per 1,000 live births)			
		7 days	7–18 days	29 days–6 months	7–12 months
1968*					
All Infants	137	43	31	39	24
Males	136	46	33	36	21
Females	138	40	28	43	27
1969**					
All Infants	140	43	32	43	22
Males	132	44	30	38	20
Females	148	41	35	48	24

*Excludes Bihar, Haryana, Himachal Pradesh, Madhya Pradesh, Nagaland, Orissa, Tamil Nadu and West Bengal and Union Territories.

**Excludes Bihar, Himachal Pradesh, Madhya Pradesh, Nagaland, Orissa, West Bengal and Union Territories.

Source: SRS Bulletin, Vol. VI, No. 3 & 4, July-December 1972, Registrar General of India, Ministry of Home Affairs, Government of India.

TABLE 15

Age-structure, India 1971

(In thousands)

Age group	Total			Rural			Urban		
	Total	Males	Females	Total	Males	Females	Total	Males	Females
0–4	78,337	39,789	38,548	64,355	32,631	31,724	13,982	7,158	6,824
5–9	82,067	42,419	39,648	67,434	34,841	32,593	14,633	7,578	7,055
10–14	67,619	35,841	31,778	54,133	28,723	25,410	13,486	7,118	6,368
15–19	47,548	25,253	22,295	36,620	19,311	17,309	10,928	5,942	4,986
20–24	43,050	21,436	21,614	32,536	15,691	16,845	10,514	5,745	4,769
25–29	40,547	20,008	20,539	31,622	15,216	16,406	8,925	4,792	4,133
30–34	36,064	18,118	17,946	28,483	13,931	14,552	7,581	4,187	3,394
35–39	32,794	17,116	15,678	26,940	13,312	12,628	6,854	3,804	3,050
40–44	28,290	15,035	13,255	22,583	11,750	10,833	5,707	3,285	2,422
45–49	22,732	12,358	10,374	18,262	9,736	8,526	4,470	2,622	1,848
50–54	20,462	11,074	9,388	16,700	8,938	7,762	3,762	2,136	1,626
55–59	12,517	6,704	5,813	10,321	5,485	4,836	2,196	1,219	977
60–64	14,246	7,408	6,838	11,870	6,163	5,707	2,376	1,245	1,131
65 and over	19,220	9,861	9,359	16,034	8,225	7,809	3,186	1,636	1,550
All ages	5,45,493	2,82,420	2,63,073	4,36,893	2,23,953	2,12,940	1,08,600	58,467	50,133

Note: Estimated from 1% sample data.

Source: Census of India, 1971, Series I, Part II, Special, Registrar General & Census Commissioner, India.

CHAPTER II

CHILD HEALTH

"In the children of today tomorrow has its being.
They are from year to year the human harvest,
good or bad according as we men and women
till the field of child life."

—John Galsworthy

Health can legitimately be defined so broadly that it becomes virtually indistinguishable from general well-being. The World Health Organisation, for example, views health as "a state of complete physical, mental and social well-being and not merely as the absence of disease or infirmity".[1]

The impact of ill-health on the individual is far more widely recognised than is the impact of inadequate nutrition. Nutrition and infection are so closely related that the same sort of deleterious effects attributed to nutrition such as stunted mental and physical development—might with usual force be blamed on poor health resulting from other causes.

Status of Child Health

Although India even now is far from a healthy nation; its accomplishments in the field of health over the past fifty years have been impressive. Specially during the past two decades, commendable improvements have taken place in the health indices of the country. The achievement may be simply summarised by pointing to the crude death rate, which is now one-third of what it was in 1920, and the life expectancy at birth which has gone up from 32 years in 1951 to 50 years

in 1971. Infant mortality, as noted earlier, has also gone/down, from a rate of around 220 in 1920 to the present 140 or so (Table: 16). As a result of these improvements, the average Indian born today can look forward to living 50 years, compared to 20 years in the decade 1911-21.[2]

The most easily-identifiable cause of these improvements in the post-Independence years is the series of campaigns against communicable deseases executed by the Indian Government. The National Malaria Eradication Programme brought the annual number of attacks down from 70—80,000,000 in the early 1950's to under 100,000 by the mid-1960's and the anti-smallpox vacination drive reduced the number of smallpox cases from 160,000 to 16,000 between 1950 and 1970. Cholera deaths were reduced by two-thirds, from 280,000 during 1951-60 to 96,000 during 1961-70. Plague was virtually eliminated as a cause of death during the same period.[3]

Despite all these achievements, the position is still far from satisfactory. The statistics on death rate, infant mortality and expectancy of life at birth, taken by themselves, may be seriously misleading. For they conceal tremendous differences in the incidence of illness and poor health among different segments of the population. The limited number of local health surveys available indicate that there are marked differences from one region to another, form rural to urban areas; and from one income-group to another. These inter-group health differences point to the existence of large seriously disadvantaged segments of Indian society i.e. young children, especially girls, from low-income or low-status families in rural areas.

Young Indian children, like young children in all countries, are more likely to become ill or die than are adults. As noted earlier, nearly 14 per cent or one-seventh of Indian children die before they reach their first birth day. Any child reaching this landmark will have survived the first two crises of his life: first, the adjustment to the change from womb environment to

the contaminated outside world during the first weeks of life; second, the change from pure breast-milk to less digestible and often unhygenic food from outside environment, beginning about the third to ninth month of life. From these two high points, the risk of death falls rapdily, so that the five-year old child faces only around a 0.6 per cent of risk during the next year; the 10 year old child runs only a 0.2 per cent risk during his eleventh year.[4]

There are no reliable data on the exact extent of morbidity among children. But we have enormous indirect evidence of the extent of morbidity by the observations of paediatricians, general physicians, research workers etc. A vast majority of common diseases occur in early childhood stages. The disease pattern in India has also shifted dramatically. While major epidemic diseases have been, by and large, eliminated as quantatively significant causes of death and ill-health, malnutrition lingers on as a significant behind-the-scene cause of death and disability. Epidemic diseases have been replaced by less specific dysenteries and diarrhoeas, respiratory diseases, gastro-intestinal disorders which together account for over 50 per cent of infant deaths in India. A recent medical survey of a little over 200,000 school children showed 13.6 per cent to be suffering from malnutrition, 25 per cent from bad teeth and gums, and about 18 per cent from skin diseases. Many of the children examined suffered from all the three ailments.

Many children are ushered into the world without the protection of medical services, grow up without medical supervision, and are reared by parents who have received no guidance from the community in the most elementary principles of child health and care. On top of it, they have to contend with poverty, hunger, ignorance and disease. A UNICEF Report on health needs of the young child indicates that; "the lack of focus on the young child may be attributed to the scarcity of resources and other priority demands, the dispersed plus twilight status of the pre-school child, and the health needs of the young being less felt by the community."[5]

The Indian child starts life a little weaker than the average European or American child—but as Indian Council for Medical Research Surveys point out—he is left far behind later on, and between the ages of two and five, his physical development is alarmingly slowed down by malnutrition and ill-health. Tables: 19-20 show that, while the one year-old Indian child starts with a deficit of 1.6 cms. in height (about 2.3%); by the age of 5 years the deficit increases to 8 cms. (5.5%). The deficit in body weight is much more marked than the deficit in height. Thousands of children develop rickets, kwashiorkor, marasmus; millions suffer from nutritional anaemia, Vitamin A and B deficiency, poor eye-sight, and retarded mental development.

At the heart of the problem of the young child, is the problem of the mother. One cannot be reviewed in isolation from the other, so closely are mother and child related. From the time of conception both mother and child need protection against disease and malnutrition. Maternity and child welfare services are, therefore, considered basic to the development of health of mother and child. The primary health needs, as determined by the experts are that, (a) every expectant and nursing mother maintains good health, learns the art of child care, has a normal delivery and bears healthy children, and (b) every child lives and grows in a family unit with love and security, has healthy surroundings, receives adequate nourishment, health supervision and efficient medical attention, and is taught the elements of healthy living.[6]

The prevailing Indian situation in relation to maternal and child health reflects woeful inadequacy of achievements and immense ground yet to the covered. Women in the age group 15–45 constitute nearly 22 per cent of the total population, and children in the age group 0–14 constitute another 42 per cent. Thus health needs of nearly 64 per cent have to be met. Of these only a small percentage is being reached at present through existing child and maternity health services.

Although there has been considerable decline in maternal mortality rates in India i.e. from 10.6 per thousand births, as estimated by the Bhore Committee in 1946, to the current rate of about 2.2,[7] yet the high incidence of miscarriages, still births and maternal mortality among lower-income groups is a recurring phenomenon in India. Malnutrition and unhygenic maternity practices are mainly responsible for these.

Until now, the Government has been putting all its eggs in one basket—the Primary Health Centre (PHC) complex, a concept that was first suggested in 1945 by the Bhore Committee. There is a PHC in almost every Community Develpment Block, but many of these centres suffer from a chronic shortage of staff and equipment including medicines which are too often out of stock. A large number of PHCs are manned by personnel not suited to their job. The outreach of the PHCs in certain areas is so inadequate that less than 5 per cent women are served by them. The Bhore Committee's recommendation of a 75–bed hospital for each PHC is still far from realisation.

In the development of maternity and child health services, apart from finances, the non-availability of female personnel like auxiliary nurses, midwives and women doctors has been a serious handicap. Paediatrics, or child care is perhaps the most neglected aspect of health services in India. The number of hospital beds for children is far too short of the need. There were only 8,600 paediatric beds in 1968, when the requirement was of 16,500 beds.[8] The recommended Mudaliar Committee norm of one bed per 1000 population and one doctor per 3000-3500 population is still not within reach (Charts 7 and 8). Attempts by officials to describe this as 'inevitable' in a developing country is of little consolation in a situation where children comprise 42 per cent of the population and where, according to official figures, a survey at any time would reveal 30 per cent of school-going children to be suffering from one ailment or another.

India's health services have not only failed to control communicable diseases as evident from the rude shock of the recent Bihar smallpox epidemic, but even in programmes which are easier to implement, e.g. programmes to prevent blindness in children through the distribution of Vitamin A tablets, the control of maternal mortality by preventing anaemia in pregnant women through distribution of inexpensive iron tablets, or even in the case of control of goitre through the distribution of iodated salt, performance has been unsatisfactory.[9] The provision exists for immunising children against smallpox and TB in the respective national programmes, but the protection against the childhood diseases of diptheria and whooping cough is not given at present on a routine basis. Hardly any attention is being paid to immunise children against tetanus and poliomyelitis.

Meanwhile, the gap between rural and urban areas has been consistently widening. While 80 per cent of the population lives in rural areas, only 30 per cent of the hospital beds and 20 per cent of the doctors in the country are available there. The country has still to evolve an effective health delivery system which will suit the socio-cultural environment of its rural communities. The problem gets further aggravated by numerous other factors, notably, traditions and taboos, age-old customs and beliefs, widespread ignorance of health practices, bad communications, and acute poverty. Again, there are serious gaps in the fields of health education, provision of safe drinking water, sewage disposal and other areas of environmental sanitation.

It can thus be seen that the gaps between the health services offered to young children and their mothers and services as needed by them are staggering.

Child Health: Programmes and Services

The directions and guidance provided by the Health Survey and Development Committee(Bhore Committee : 1946)

and the Health Survey and Planning Committee (Mudaliar Committee : 1961) have been the chief basis for health planning in India. The broad objectives of the health programme during the first three plans have been to:—

(i) control or eradicate major communicable diseases;

(ii) provide curative, preventive and promotional services in rural areas through establishment of PHCs and sub-centres; and

(iii) augment the training programmes of medical and paramedical personnel.

The *First Five Year Plan* (1951-56)[10] placed maternity and child health services in the forefront in planning health programmes and in curtailing high rate of maternal and infant mortality. The number of maternity beds was doubled to accommodate more delivery cases and to offer post-natal care for a longer period. Ten per cent of the beds were reserved for sick children. Training centres for doctors, nurses, midwives and paediatricians were strengthened with WHO and UNICEF assistance. Voluntary organisations were given more responsibility for the establishment and maintenance of a large number of MCH Centres and also for starting training programmes for auxiliary nurse-midwives, health visitors etc.

The *Second Five Year Plan* (1956-61)[11] highlighted nutrition as the most important single factor in health maintenance. It recommended a nutrition programme on a priority basis for the *vulnerable groups of the population*, such as expectant and nursing mothers, infants and children of school going age. Maternity and child health services were integrated with the PHC during the plan period. Paediatrics was identified as the weakest link in maternity and child health services, and remedial measures to ensure a steady supply of paediatricians were initiated.

During the *Third Five Year Plan* (1961-66)[12] the process of integrating maternity and child health services with the

PHC complex received increasing support. Training programmes for paramedical personnel, specially those required in rural areas, were accorded high priority.

Under the *Fourth Five Year Plan* (1969-74)[13] the family planning programme was accorded the highest priority. To make this programme more effective and acceptable it was suggested that the maternity and child health services be integrated with the family welfare planning centres. These centres were equipped to offer immunisation, health check-up and nutrition services for young children and pregnant and nursing mothers. Table: 22 shows the quantum of existing facilities for maternal and child health services by the end of March 1971, as reported by the Ministry of Health and Family Planning. Another table (Table: 21) presents data on health and family planning institutions and manpower position from 1951 to 1971.

The PHC is the keystone of the health network in the country. One PHC has been established in almost every one of the country's Community Development Blocks (with a population of around 100,000 each). By 1970-71 the reported number of PHCs was 5,112. Each PHC has two doctors—one for health and the other for family planning—and a supporting staff of nurses, midwives, vaccinators, dressers, and other paramedical personnel. Below each PHC are five or six sub-centres (29,175 in 1971), each staffed by one or two auxiliary nurse-midwives and some supporting staff. These sub-centres serve primarily as out-patient clinics and as a base from which auxiliary nurse-midwives go out for delivering maternity and child health and care services. According to Health Ministry reports, this network receives nearly 200 million patient-visits per year and about 40-50 per cent of child births are supervised by trained midwife, nurse, or doctor.[14] The Committee on Programmes for Children (1968) estimated the proportion of rural mothers who received skilled assistance at the time of delivery,

varying from 20 per cent to 50 per cent in different parts of the country. The rest were assisted by dais and traditional birth attendants.[15]

During the past two decades of developmental planning, commendable improvements have taken place in the health indices of the country. The mortality rate has declined from 27.4 per thousand in the year 1951 to 15.1 per thousand in 1971. Life expectancy at birth has gone up from 32 years in 1951 to 50 years in 1971, and infant mortality rate has registered a decline from 183 to 140 during this period. The number of hospital beds is expected to increase from 1,13,000 in 1951 to 2,81,600 in 1974. The bed population ratio has also gone up to 0.49 per thousand from 0.32 per thousand in the last twenty years. Ninty-nine medical colleges with an annual admission capacity of nearly 12,500 undergraduates are now functioning as compared with 30 with an annual admission capacity of 2,500 students in 1951.[16]

The *Fifth Five Year Plan* (1974-79) section on health says that, "the primary objective during the Fifth Five Year Plan is to provide minimum public health facilities integrated with family planning and nutrition for vulnerable groups—children, pregnant women and lactating mothers". The accent during the Fifth Plan willbe on:

(i) increasing the accessibility of health services to rural areas;

(ii) correcting the regional imbalance;

(iii) intensification of the control and eradication of communicable diseases especially malaria and smallpox;

(iv) qualitative improvement in the education and training of health personnel; and

(v) development of referral services by providing specialist's services in rural areas.[17]

Under the National Programme of Minimum Needs, the PHC complex will still remain the nucleus around which the rural health care services will be built up. Backward and tribal areas which have so far been neglected will receive priority treatment in the implementation of the health programmes.

The Fifth Plan targets are: (i) one primary health centre for each community development block, (ii) one sub-centre for a population unit of 10,000, (iii) making up the backlog and deficiencies in buildings, staff, equipment etc., (iv) provision of drugs at the enhanced level of Rs. 12,000 per annum per PHC and Rs. 2000 per annum per sub-centre, and (v) upgradation of one in every four PHCs to 30-bed rural hospital. These goals are to be achieved through (a) the integration of health, family planning and nutrition programmes, (b) the augmentation and reorientation of training programme to train a special functionary—a multipurpose health worker to deliver the integrated health care services; and (c) making up deficiencies in numbers, buildings, staff, equipment and drugs etc. of the PHC complex in a coordinated way. As a result of these measures, it is expected that by the end of the Fifth Plan deficiencies in buildings, staff, equipment and drugs at the existing PHCs would be made up and additional facilities to the extent of 101 PHCs, 11036 sub-centres and 1293 rural hospitals would be made available.[18]

For the welfare of the underprivileged children, the Fifth Plan lays emphasis on coordinating various programmes being administered by a number of agencies. As such, it has been proposed to launch an integrated child care service with emphasis on immunisation, health check-up and supplementary nutrition to reduce morbidity, mortality and in general, to promote the health of infants and children of the vulnerable segments of the population. Health measures under the school health service programme which cover detection as well as treatment of ailments among school children are proposed to be

extended to rural areas through PHCs. Health education will be woven into the general educational system of the country and health education material brought out in different languages for distribution among the people.

The programme for family welfare planning, which is inseparably linked with planning for health care services, has been accorded a high priority in the Fifth Plan. The birth rate at the beginning of the Fifth Plan is now expected to be about 35 per 1000 population. The Fifth Plan aims at reduction of birth rate by 5 points i.e. to a level of 30 per thousand population by the end of the plan period and by a further 5 points or 25 per thousand population by 1983-84. In order to achieve these targets the approach will be to increasingly integrate family planning services with those of health, maternity child health and nutrition.

Efforts will be made to convert more and more vertical programme workers into multipurpose workers who will pay special attention to family planning services. A new category of medical-aid personnel, to be called Health Assistants, will be inducted for rural health services to provide intermediate level 'manpower support' to doctors. Integration of health, family welfare and nutritional services is being attempted through multi-purpose workers at the grass root level. There will be greater attention on preventive and promotional aspects of community health in the rural areas.

The maternity and child health services in the family planning programme in the Fifth Plan include the immunisation of infants and pre-school children against diptheria, whooping cough and tetanus, and expectant mothers against tetanus, and also prophylaxis against nutritional anaemia among mothers and children and blindness in children caused by vitamin 'A' deficiency.

Many of the general anti-poverty measures, forming part of the Minimum Needs Programme, are also potentially capable

of having a significant impact on health of children. This programme, part of the Plan's stated effort to deal more energetically with poverty, consists of a package of basic services to be concentrated in poor and backward areas. Over the next five years, the Government intends to spend Rs. 2800 crores on these programmes which include supplementary nutrition, protected water supply, expansion of primary health centre net-work etc. A mechanism for effective coordination of the activities of the functionaries of health, nutrition and child care services, particularly at the village level, is to be evolved for ensuring proper delivery of the package of services. While immunisation and health check-up would be the responsibility of the auxiliary nurse-midwife (ANM) of the sub-centre, the other functions will be entrusted to the Balsevika, a multi-purpose functionary to be appointed under the proposed integrated child care services programme. The Balsevika would seek the cooperation of ANMs and health workers of the PHC, the school teachers and local volunteers in carrying out her functions. Similarly, at the block level the PHC and the block agency will have functional collaboration for the successful implemention of the programme. The block extension educator, the lady health visitor and the public health nurse would provide the necessary support and supervision to the ANM and Balsevika.

Thus, the following elements are pronounced in the Government's health strategy:—

(i) integration of health, family planning, nutrition and other related services for rural communities, especially mothers and children;

(ii) strengthening the infra-structural base of health services;

(iii) improving and expanding traditional health service structure;

(iv) evolving a mechanism for effective coordination of the activities of different functionaries at various levels; and

(v) providing greater attention to preventive and promotional aspects of community health through induction of multi-purpose para-medical staff at the grass-root level.

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Chart: 7

Actual position 1972-73 and requirement of medical and para-medical personnel

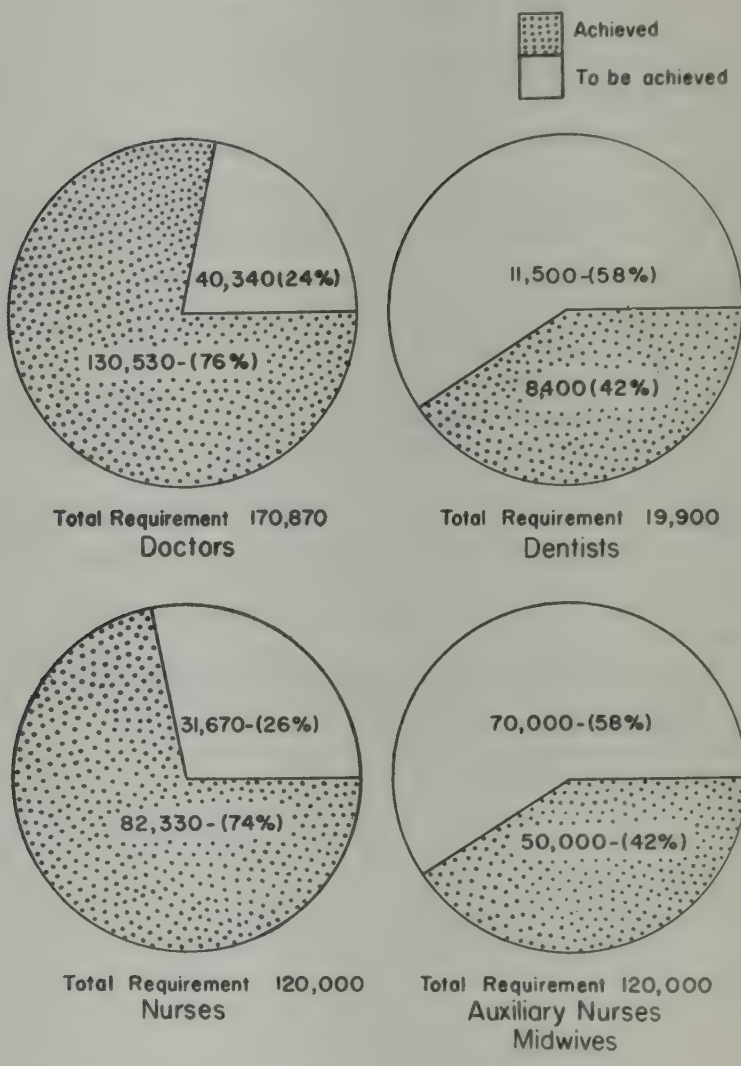


Chart: 8

Actual Ratio to Population 1973-74 and Recommended Ratio to Population by the Health Survey and Planning Committee of Medical and Para-medical Personnel

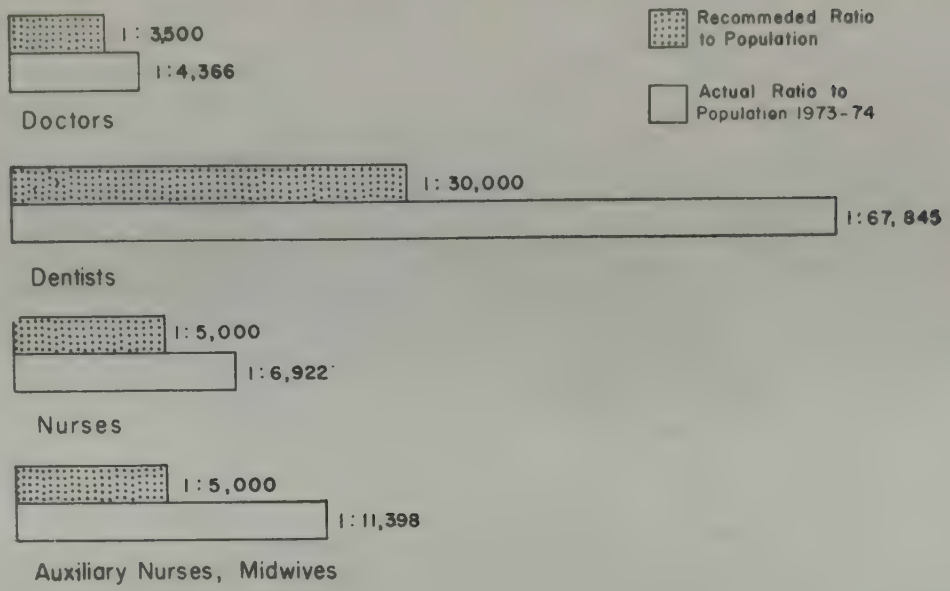
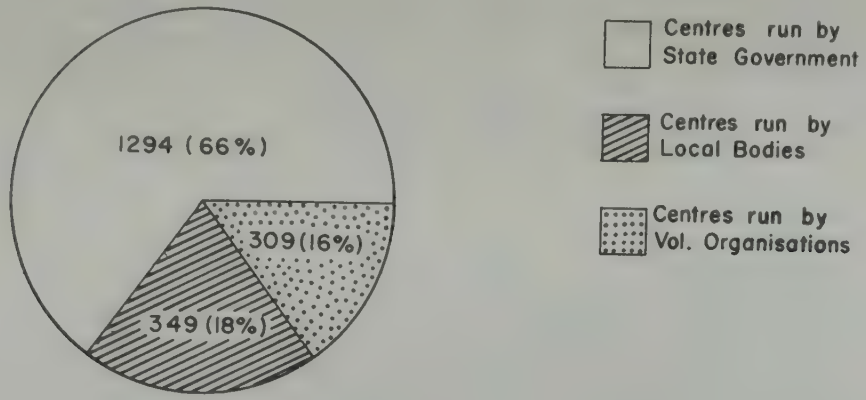


Chart : 9

Urban Family Welfare Planning Centres - India as on 1·9·72

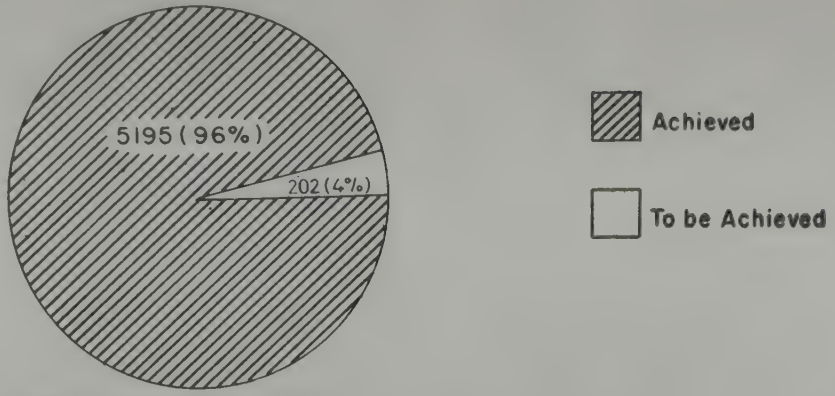


Total UFWP Centres = 1952

Source : Ministry of Health and Family Planning Report 1972-73, Government of India

Chart : 10

Percentage Achievement of Family Welfare Planning (F W P) Centres (as on 1·9·72)



Total Requirement, 5397

Source : Ministry of Health and Family Planning Report- 1972-73, Government of India

TABLE 16

Health Indices—Comparative Figures of Years 1951 and 1971

	1951	1971
1. Mortality Rate	27.4 per thousand	15.1 per thousand
2. Life Expetancy at Birth	32 years	50 years
3. Infant Mortality Rate	183 per thousand	140 per thousand
4. Number of Hospital beds	1,13,000	2,81,000
5. Bed population ratio	0.32 per thousand	0.49 per thousand
6. Medical Colleges	30	99
7. Admission Capacity	2,500	12,500

Source: Draft Fifth Five Year Plan, Government of India, Planning Commission, Vol. II, pp. 233-34

TABLE 17

Average Height of Indian Boys (cms)

Age in years	Rural	Urban
1	73.8	73.9
2	81.1	81.9
3	87.5	89.6
4	94.4	96.9
5	101.1	102.7

TABLE 18

Average Weight of Indian Boys (Kg.)

Age in years	Rural	Urban
1	8.3	8.4
2	10.1	10.3
3	11.8	12.0
4	13.4	13.7
5	14.7	15.0

TABLE 19

Comparative Heights of Indian and American Boys (cms)

Age in years	50th percentile for Indian Children	50th percentile for American Children
1	73.54	75.2
2	81.77	87.5
3	88.56	96.2
4	95.91	103.4
5	102.24	108.2

TABLE 20

Comparative Weights of Indian and American Boys (CMS)

Age in years	50th percentile for Indian Children	50th percentile for American Children
1	8.26	10.07
2	10.01	12.56
3	11.77	14.61
4	13.36	16.51
5	15.22	18.37

Source: M. V. Phadke and H. D. Kulkarni, 'Growth and Development of Pre-school Children, in *Report of the Seminar on the Pre-school Child*, Madras: ICCW, 1973, pp. 32-33.

TABLE 21

Health and Family Planning Institutions and Manpower

Item	Unit	1950-51	1955-56	1960-61	1965-66	1970-71
Hospital beds	,000	113.0	125.0	186.0	240.1	266.2
PHC	number	—	725	2,800	4,631	5,112
Family Planning Centres	,000	—	147	1,649	12,138	36,800
Medical Colleges	number	30	42	57	87	95
Doctors	,000	56.0	65,0	70.0	86,0	115.7
Nurses	,000	15,0	18,5	27.0	45.0	68.5
ANMs	,000	8.0	12.8	19.9	36.0	57.0

Source: Country Statement for Inida, Second Asian Population Conference, Tokyo 1-13 Nov. 1972, Council for Social Dovement (Table A-16).

TABLE 22

Existing Facilities for Maternal and Child Health Services by the end of March 1971

1. Rural M.C.H. Centres	7072	8. Children's Hospitals	25
2. Rural PHCs	5044	9. Children Ward in Gen. Hospitals	424
3. Rural sub-centres	29175	10. Number of Maternity beds	47596
4. Urban M.C.H. Centres	1419	11. Number of children beds	9353
5. Urban Maternity Homes	443	12. Urban Familly Welfare Planning Centres	1783
6. Maternity Hospitals	404		
7. Maternity wards in General Hospitals	1226		

Source: Swasthya Aur Parivar Niyojan Mantralaya Report for 1970-71, Ministry of Health and Family Planning, Government of India, pp. 206-208.

TABLE 23

Availability and requirements as per norms recommended by the Health Survey and Planning Committee of Medical and Paramedical personnel

Category	Recommended Ratio fo population	Requirement	Expected Availability	Actual position (1972-73)	Ratio to population (1972-73)
Doctors	1: 3,500	170,870	137,930	130,530	1: 4,366
Dentists	1: 30,000	19,900	8,754	8,400	1: 67,845
Nurses	1: 5,000	120,000	88,000	82,330	1: 6,922
Auxilliary Nurses Midwives	1: 5,000	120,000	54,000	50,000	1: 11,398

Source: Ministry of Health & Family Planning Report 1972-73, Government of India.

CHAPTER III

CHILD NUTRITION

"Whatsoever was the father of a disease an ill diet was the mother."

—George Herbert

Nutrition, a field of activity traditionally viewed as humanitarian, is now justified on development grounds. It has been recognised that the staggering mortality resulting from malnutrition and the reduction of mental and physical performance constitute a major impediment to national development.

STATUS OF CHILD NUTRITION

India's levels of intake appear to be among the world's lowest. The average Indian consumes about 50 to 60 per cent of the amount of protein and calories received by an average European or American. His daily intake of around 2000 calories is about 15-20 per cent below the daily allowance recommended by the ICMR. The average Indian's protein intake of 55 gms. daily is, however, 25 per cent above the ICMR's recommended allowance of 44 gms. per day, although a large enough percentage of the Indian population continues to receive inadequate amount of protein.[1] The daily per capita availability of calories rose from around 1700 in 1949-50 to slightly over 2000 in 1960-61 and that of protein from around 45 grammes per day to a little over 50 grammes per day during the same period and have remained steady at this level since then, or perhaps even declined slightly during the 1960s and early 70s.[2]

Distribution of Inadequate Nutrition

Inadequate nutrition is very unevenly distributed in the country. *First*, protein-calorie malnutrition is two to three times as prevalent in the rural parts of Southern and Eastern India as in the rural parts of North and West, as illustrated in Table: 24. The same pattern of regional differentiation in calorie consumption emerges from the diet surveys of National Institute of Nutrition and State Health Departments.[3] *Second*, urban dwellers appear to eat less well than the rural people. *Third* and not surprisingly, poor people are less well nourished than those who are better off, although the magnitude of difference remains unclear. *Fourth*, the special groups most vulnerable to inadequate nutrition-children, pregnant women and nursing mothers—are probably worse off nutritionally than the population as a whole.

The particular concern for these special groups centres around the need for young children to receive relatively high nutritive intakes, coupled with the potentially severe consequences for their physical and mental development if they fail to receive them. The pregnant mother needs 15 per cent more calories and 25 per cent more protein than her non-pregnant counterpart. The nursing mother needs one-third more calories and protein than the non-nursing, non-pregnant women; and the growing child requires around two-thirds more protein and calories per kilogram of weight than his father and mother.[4]

But these women and children who need more and better food are not getting it. The average Indian child 1 to 5 years old has an average daily calorie intake of only 810, compared with ICMR's recommended allowance of 1200. Average vitamin intake is just 60 milligrams daily against recommended allowance of 250-300; daily iron intake is about 6 mgs. against 15-20; calcium consumption is just under 200 mgs. per day compared with the recommended 400-500. These deficiencies are shown more graphically in Table 25, drawn from the *Diet Atlas of India*.

These average figures (see Table 26 also) suggest that around 80 to 90 per cent of Indian children receive inadequate amounts of these key vitamins and minerals; that 75 per cent receive inadequate calories and around 50 per cent do not get enough protein. Even these small intakes may not be fully absorbed because of intestinal infections and diahoerrea.

Similarly, the average pregnant woman consumes 1400-1500 calories and 35-40 grammes of protein, compared with the 2500 calories and 55 grammes of protein she needs. The average nursing mother consumes about the same amount compared with her daily need of 2900 calories and 65 grammes of protein.[5] Thus the problem of malnutrition in India begins to show its damaging effects even before a child is born. A high incidence of prematurity and neo-natal mortality in India is attributed to serious malnutrition among expectant mothers.

Furthermore, the national averages, it is pointed out, are misleading and hide the existence of pockets of severe malnutrition in the country. Foods available in the country are not distributed according to physiological needs. The Ganga Saran Sinha Committee (1968) observed that the actual dietary and nutrient intake of infants and young children of 1-5 years age group did not correspond with the national per capita average of daily food and nutrient intake. Among its various reasons, the Committee took note of the practice of prolonged breast-feeding, reluctance of mothers to introduce solid nutritious foods for fear of gastro-intestinal upsets, and influence of social customs, food practices, taboos and prejudices.[6]

Impact of Inadequate Nutrition

The nutritional inadequacies are major contributory factors to frequent illness and slow growth and development among Indian children. The trouble starts with the pregnant woman who fails to obtain adequate protein and calories. Her baby

weighs nearly a pound less than the baby of her better nourished counterpart.[7] These underdeveloped babies are more likely to die during the first few months of their lives, or if they survive, are more likely to suffer severely from subsequent infections. As reported earlier, about 40 per cent of the total deaths in India take place among children below 5 years as against 7 per cent in technologically advanced countries of the West. Though there has been a steady decline in the overall mortality rate in India over the last two decades, the infant mortality rate has more or less remained stationary.

Thus, an average Indian child starts life a little weaker than an average European or American child and a considerable proportion of the child population in India never reaches adulthood. The figures collected by the National Institute of Nutrition indicate that nearly 100,000 children die every month as a result of malnutrition. Far more greater in numbers are children who die of infectious diseases which, but for their poor diet, would not have developed at all or would not have ended fatally. This enormous wastage of children is apparently a motivation for large families, especially among the rural poor. We are thus caught in a vicious circle of malnutrition leading to high child mortality which in its wake motivates large families resulting in further aggravation of malnutrition.

In a field study, covering 1,400 pre-school children, it was found that while 32 per cent of children belonging to birth orders 4 and above exhibited various signs of malnutrition, only 17 per cent of children of earlier birth orders showed such symptoms. The heights and weights of pre-school children displayed negative correlation with family size. The data revealed that 62 per cent of all nutritional deficiencies were encountered in children of birth orders 4 and above. This implies that even under the current economic and living conditions, mere limitation of family size to three children can bring down the incidence of malnutrition in pre-school children by about 60 per cent.[8]

The most crucial period in a child's growth is the first six years of life, since about 40 per cent of physical growth and 80 per cent of mental growth are believed to take place during these years. It has been established that the poorly nourished child grows less rapidly. By the age of 5 years, the average Indian child weighs around 3 kilograms or 15-20 per cent less and is 5-10 centimeters or 5 per cent shorter than the average American child as has been illustrated by Charts 13-14. By the age of fifteen, the Indian child weighs 25-30 per cent less and is 5-10 per cent shorter than the American child.

Protein-calorie malnutrition has been identified as a major problem in India, especially among children below 5 years. A recent comprehensive country-wide survey carried out by the ICMR on 18,356 one to five-year old children reveals that 92 per cent of them suffer from malnutrition, nearly 69 per cent of children between 1 and 3 and 44 per cent between 3 and 5 suffer from nutritional anaemia, and nearly 7 per cent from caries, a dental disease.[9] According to another survey conducted in November 1972 by the ICMR, at least 60 per cent of all children in India suffered from nutritional anaemia and half of the 100 million children between the age one and six from protein-calorie malnutrition in one form or the other.

It has been estimated that there are about 60 million malnourished children in the country and 25 million of these children may go blind because of vitamin 'A' deficiency[10]. 'Nutritional dwarfism' is a common feature among the child population in the country. But clinically recognisable malnutrition is only the visible portion of the iceberg of malnutrition. It is estimated that for every child who shows clinical signs of kwashiorkor or marasmus, there are probably at least four children suffering from milder grades of malnutrition without clinically apparent symptoms.

The poorly nourished child may also develop less well mentally. Malnutrition during the growing periods of infancy and early childhood leaves permanent physical and psychological scars in later life in those who survive and the damage

done to mental growth is often permanent and irreversible. Available evidence indicate that children suffering from protein-calorie malnutrition, severe enough to produce the clinical symptoms, perform less well mentally than adequately nourished children and continue to lie under the shadow of this imperceptible tragedy. The mental performance of children recovered from kwashiorkor has been placed at around 50 per cent of normal children.[11]

Maternal mortality rates in India, again, are about the highest in the world. For every 100,000 children born, 252 mothers die. For the developed countries, the rate never exceeds 40. But even this maternal mortality rate, says a study report of the National Institute of Nutrition, "grossly underestimates the total quantum of ill-health and malnutrition among the women of the reproductive age (who represent nearly 23 per cent of the Indian population)". Another study has shown that "the body weights of women in the reproductive period ranged from 39 to 44 kgs. (which is extremely low compared to Western standards); 44 per cent of pregnant women suffered from Vitamin-B Complex deficiency, 15 per cent from hypovitaminosis A and nearly 10 per cent from hypoproteinaemia."[12]

Malnutrition: Factor of Poverty and Ignorance

In a review like this it is not possible to mention all the factors related to the incidence of child malnutrition. It has been pointed out that malnutrition is so intimately linked with health and the other elements of the poverty syndrome that an effort to distinguish between cause and effect is almost fruitless.[13] One factor that is not entirely clear is how far malnutrition is a function of poverty and how far it is due to lack of knowledge. The traditionally accepted assumption that better diet is a function of increased income may apply in certain societies and at certain income levels. However, in some situations there may be an inverse correlation between the two, particularly when income increases are modest and

start from a low base. People may eat more but not necessarily better. The common example in India is the shift with the first increment of income from millet to rice, from home-pounded rice to polished rice, and from jaggery to the less beneficial refined sugar. In a rural setting, increased incomes usually result from the reorientation of traditional agricultural production practices. However, attractive price incentives for wheat, are considered partly responsible for the declining acreage used to grow high protein pulses. As wheat production has gone up, the per capita production of pulses—a major protein source in the Indian diet—has declined 27 per cent.[14]

It seems that often the lack of knowledge among adults, especially the mothers of young children, is a major cause of malnutrition in growing young children. Many of the factors result from deep-rooted beliefs and values which are slow to change. In India, poverty is undeniably a very potent factor in undernutrition or malnutrition of the young child. Poverty is primarily an economic condition, but its correlates invariably extend to all aspects of a child's development.

As a result, there are no easy answers in the nutrition field, no panaceas, no programmes that do not suffer from some conceptual as well as operational limitations, particularly if undertaken in isolation from one another. A broad nutrition strategy, therefore, will have to include programmes which are directed at increased food production, removal of poverty; nutrition interventions through food subsidization and distribution and through supplementary feeding programmes, and nutrition education.

CHILD NUTRITION—PROGRAMMES AND SERVICES

India is considered a leader among the world's developing nations trying to provide adequate nutrition to its people. The seriousness of the problem of undernutrition and malnutrition and the need for improving the nutritional status of the people

have been increasingly recognised in the successive five year plans of the country.

The *First Plan* (1951-56) recognised nutrition as the most important single factor in the maintenance of health and resistance to disease. It laid special stress on the adverse effects of malnutrition on infants and expectant mothers and recommended introduction of supplementary feeding of mothers and infants through maternity and child welfare centres; school feeding programmes; education in nutrition, and production of nutritive foods.

The *Second Plan* (1956-61) reiterated that in improving nutritional status priority should be given to vulnerable groups of population, namely expectant and nursing mothers, infants, toddlers, pre-school children and school going children. Provision was made in the plan for nutrition research and establishment of nutrition laboratories.

The *Third Plan* (1961-66) contemplated nutrition improvement services under two broad heads, namely, (i) nutrition education to various sections of the community; and (ii) measures to meet nutritional requirements of vulnerable groups within the community. The importance of improving the nutritional status of the pre-school and school-going children and also of pregnant and nursing mothers was re-emphasised. School children were to receive supplementary nutrition through the mid-day meals scheme and the nutritional status of pregnant and nursing mothers was to be improved through nutrition education.

Feeding Programmes

In persuance of the recommendations of the National School Health Committee, the *scheme of providing mid-day meals* to primary school children was initiated during 1962-63, as a centrally sponsored scheme. After the Third Five Year Plan, the scheme was transferred to the states with central assistance fixed at 40 per cent of the expenditure. During

the period of drought, the mid-day meal programme was extended to all affected areas. Most of the food supply came from CARE. At present, about 12 million beneficiaries, including pre-school and school children and expectant and lactating mothers, are estimated to be covered through this programme.[15]

Experience over several years in implementing programmes of supplementary feeding for children and pregnant and nursing mothers indicated that unless qualitative changes in food production were brought about at the village level, the problem of malnutrition could not be dealt with successfully. This realization led to the adoption of an *expanded nutrition programme* in the States of Orissa, Andhra Pradesh and Uttar Pradesh between 1960 and 62. After three years of experimentation, the programme was extended to the entire country in 1963 as the *Applied Nutrition Programme* (ANP). The programme, which covered 221 community development blocks during the Third Plan period, now extends to 1,172 block, covering about 20 per cent of the rural area (Table 27).

The Applied Nutrition Programme, operated by the State Community Development Departments, was designed to bring to community development blocks an integrated package of nutritional inputs including programmes to increase the local production of protective foods (through schemes of poultries, fisheries, community and school gardens, community dairies etc.); the organization of supplementary feeding programmes for needy women and children; and nutrition education of mothers through women's organisations in the villages, schools, community development and health personnel and personnel of other development agencies. But it has been observed that in very few villages did more than one programme element get off the ground. The UNICEF supported supplementary feeding programme received greater attention in the bargain and is now covering around 1.7 million women and children daily.[16]

The Bihar famine of 1966-67 dramatised the magnitude and implications of malnutrition and led to a significant acceleration of the already growing governmental concern. The result was an articulate Governmental policy (considered the first formal governmental policy declaration anywhere in the world) was spelled out in the *Fourth Five Year Plan* (1969-74) that allocated Rs. 45 crores for nutrition during the plan period. Shortly thereafter, the ruling Congress Party adopted a 'Children's Charter' which called for additional child nutrition programmes involving an expenditure of an additional Rs. 60 crores during the Fourth Plan period.

The Fourth Plan made the first serious attempt to frame a coordinated nutrition programme. It observed that "where so many are undernourished, more food is the first step towards nutrition." The Plan, therefore, visualised stepping up of agricultural production along with animal husbandry and fisheries as the basis of all effort in nutrition. At the same time specific programmes of nutrition having impact in the short run were given high priority.

The Department of Social Welfare introduced the *Supplementary Nutrition Programme* (SNP) in 1971-72 to provide for supplementary nutritoin to pre-school children in urban slums and tribal areas. Its purpose was to combat malnutrition among young children and among expectant and nursing mothers living in depressed and relatively inaccessible areas. It was envisaged that children below 1 year would receive about 200 calories of food and 8 to 10 gms. of good quality protein, and children between 2 and 6, 300 calories and 12 gms. of protein. Expectant and nursing mothers were to receive 500 calories of food and 25 gms. of protein, folic acid, iron and multi-vitamins. The feeding programme initially provided for 250 days a year and was later extended to 300 days. So far about 3.8 million beneficiaries have been covered under SNP through about 28,000 feeding centres operating in various parts of the country[17] (Table 28)

In addition to the Supplementary Nutrition Programme, the Department of Social Welfare is implementing a *Nutrition Programme for Children* in the age-group of 3-5 years, through balwadis and day-care centres run or sponsored by the Central Social Welfare Board. Under this programme children are given supplementary food consisting of approximately 300 calories and 15 gms. of protein daily for 250 days in a year at the cost of 15 paise per child per year. By 1973-74, 2.3 lakh beneficiaries including pre-school children and expectant and nursing mothers were covered through 6059 balwadis maintained or supported by the CSWB, Indian Council for Child Welfare, Harijan Sevak Sangh and Adimjati Sevak Sangh[18] (Table 28).

Altogether, these supplementary feeding programmes serve around 10-12 per cent of the population in their respective target groups.[19] There is little information available on the nutritional or socio-economic status of the individuals they serve. The mid-day meal programme largely reaches only school children of six years of age and above. A study of the Orissa School Lunch Programme revealed that the programme served 70 per cent of schools or so in predominantly tribal areas, compared with 25-30 per cent of schools in nontribal areas.[20] The ANP appears to serve all socio-economic classes more or less equally. The SNP figures better in this respect as it serves only younger children and needy mothers in depressed and backward areas.

Fortification Innovations

Nutrition as a profession is fairly developed in India. For the past half-century India's laboratory and clinical work in the field of nutrition has ranked with the finest in Asia.[21] However, the laboratory findings often remained confined to the academic world and malnutrition continued to be regarded as a welfare problem and addressed accordingly by policy makers and planners. India's first venture into fortification of cereal foods came with the introduction of Modern Bread in

1968. Nine units of Modern Bakeries have been set up in the country with an annual production of 100 million standard loaves.

Another important scheme for production of nutritious food is that of 'Balahar'—a low-cost locally produced, nutritious cereal 'mix' that combines wheat with inexpensive oilseed protein. Till 1972-73, about 38,000 tonnes of Balahar was produced in collaboration with Kaira District Milk Producer's Union, Anand. The production of Miltone, a protein-isolated toned milk from groundnut at the Government Dairy, Bangalore, has been about 7.20 lakh litres. Two more units are expected to go into production at Hyderabad and Ernakulam. Fortification of wheat flour, on a pilot project basis, has been undertaken and about 53,000 tonnes of fortified 'Ata' had been produced up to December 1972. Research is also taking place on the fortification of salt and tea—two very commonly used food items in India.

Nutrition Education

As pointed out earlier, income increases alone do not guarantee adequate nutrition among the poor. Nutrition education involving dissemination of knowledge regarding proper food has a significant role in facilitating optimum use of food resources available. Nutrition education is being promoted through ANP, composite nutrition programme for women and young children, mobile nutrition extension units, food preservation centres and a variety of other programmes for training, extension and education in nutrition. Recent experimentation has shown the mass media to be potentially more effective in communicating nutrition message to the target population.[33]

Health-based Nutrition Programmes

Another major scheme is for prophylaxis against nutritional anaemia in mothers and children, covering 15 million beneficiaries including 9 million children. Children in the age-group

1-5 years are given a large dose of vitamin 'A' under the scheme initiated to control blindness once in six months. About 12 million children are being covered under this scheme. Upto the end of 1971-72, about 10 lakh children were covered in the scheme for distribution of iron and folic acid supplementation.

Nutrition in the Fifth Plan

The *Fifth Five Year Plan* (1974-79) has postulated care of pregnant women, lactating mothers and pre-school children as an essential part of the Minimum Needs Programme. The approach document has said:—

> "In order to attack the problem of malnutrition at its root, it will be necessary to take care of pregnant women, lactating mothers and pre-school children of the weaker sections."

Augmenting food production and economic uplift are the two major steps that will improve the nutritional status of the community. While this object is considered as a long-term one, immediate steps have been visualised to combat existing nutritional deficiencies of calorie-protein, iron and vitamin 'A'. It is anticipated that during the Fifth Five Year Paln period, the coverage under Mid-day Meal Programme will go up from 12 million to 16.5 million and under SNP from 3.8 million to about 10 million. Production of Balahar is to be stepped up from the present level of about 30,000 tonnes per year to about 2.5 lakh tonnes per year during this period. It is proposed to set up 50 units for the production of Miltone and a chain of Modern Bakeries.

As per recommendations of the Committee on Pre-School Feeding Programmes, the feeding programmes in the Fifth Plan will be integrated with health and welfare services to form a composite package of services known as the Integrated Child Development Services (ICDS). The Applied Nutrition Programme is to be thoroughly overhauled and functionally

linked with the ICDS. The objective of the ICDS programme is to lay the foundation for the proper psychological, physical and social development of pre-school children in disadvantaged areas by improving their nutritional and health status and by enhancing the capacity of mothers to look after the basic health and nutritional needs of their children.

The package of services to be administered in the ICDS programme will lay emphasis on supplementary nutrition, immunisation, health check-up, referral services, nutrition and health education, and informal education. The programme would be implemented in about 1,000 rural and tribal community development blocks and urban slum areas during the Fifth Plan (310 rural projects, 310 urban and 380 tribal projects). The feeding centres set up under the Supplementary Nutrition Programme during the Fourth Plan period, would provide the initial operation-base for the execution of the programme. In the Fifth Plan, an outlay of Rs. 140 crores has been made for this centrally sponsored scheme in the social welfare sector in addition to funds to be made available from the health and nutrition allocations. UNICEF is likely to provide substantial external assistance in areas of consultancy service, training, supplies, equipment, monitoring, research and evaluation.

A 'National Centre for Child Development' is being set up by strengthening and reorganising the existing Central Institute of Research and Training in Public Cooperation, New Delhi. The Centre would function as a documentation and analysis base for policies and programmes affecting young child in the country.

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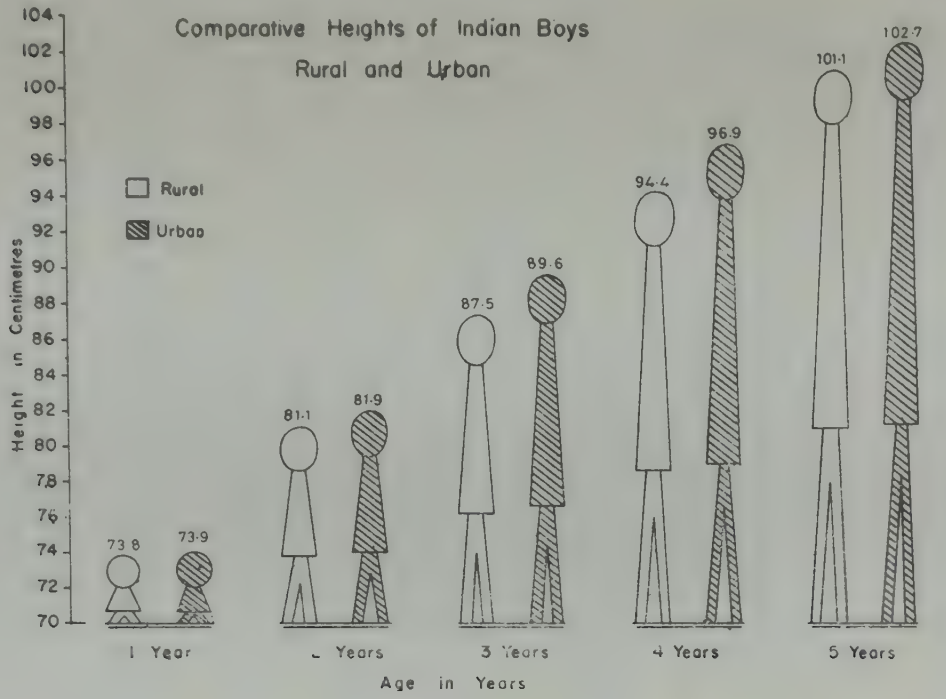
Chart - II


Comparative Heights of Indian Boys
Rural and Urban
Rural
Urban
Height in Centimetres
104
102
100
98
96
94
92
90
88
86
84
82
80
78
76
74
72
70
73·8
73·9
81·1
81·9
87·5
89·6
94·4
96·9
101·1
102·7
1 Year
5 Years
3 Years
4 Years
5 Years
Age in Years

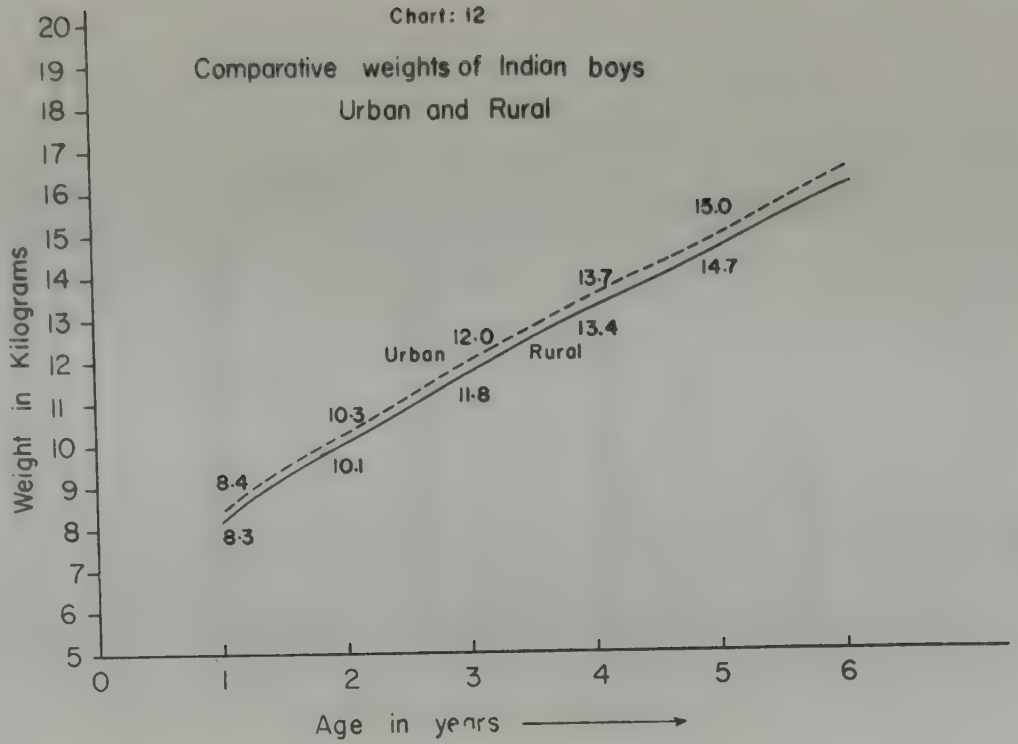


Chart: 12
Comparative weights of Indian boys
Urban and Rural
Weight in Kilograms
Age in years
Urban
Rural
8·4
8·3
10·3
10·1
12·0
11·8
13·7
13·4
15·0
14·7

Chart: 13

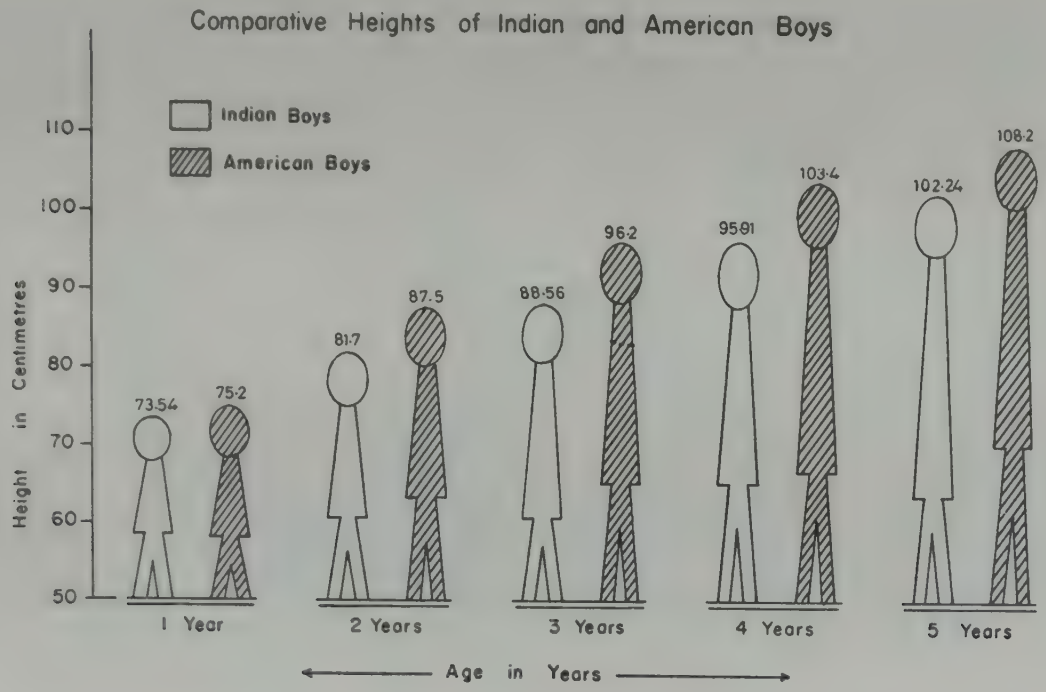

Comparative Heights of Indian and American Boys
Indian Boys
American Boys
Height in Centimetres
110
100
90
80
70
60
50
73.54
75.2
81.7
87.5
88.56
96.2
95.91
103.4
102.24
108.2
1 Year
2 Years
3 Years
4 Years
5 Years
Age in Years

Chart: 14

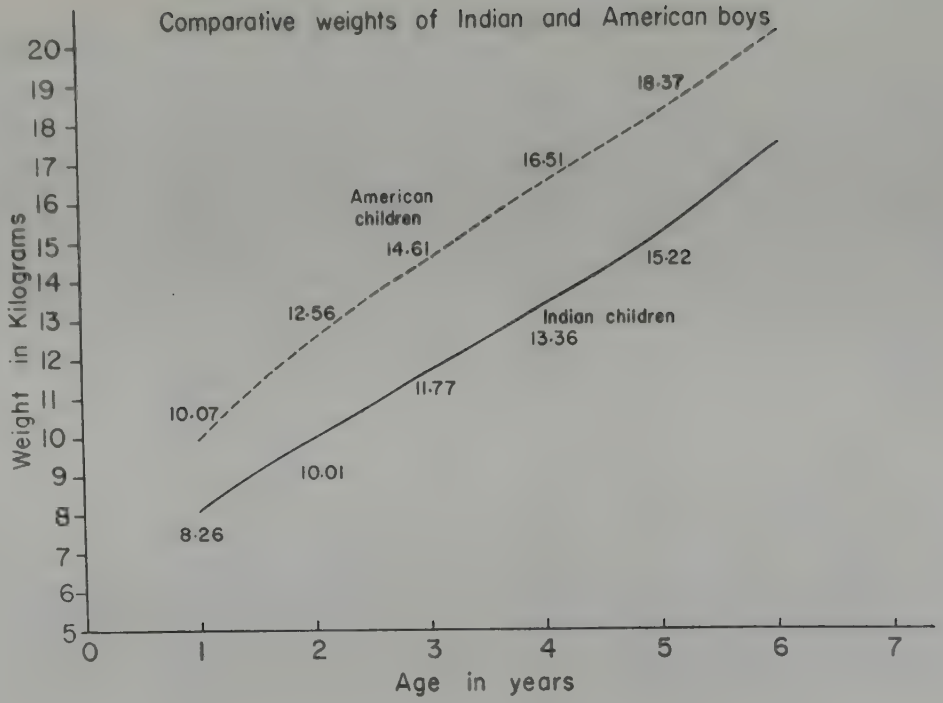

Comparative weights of Indian and American boys
Weight in Kilograms
Age in years
American children
Indian children
10·07
12·56
14·61
16·51
18·37
8·26
10·01
11·77
13·36
15·22

TABLE 24

Distribution of Inadequate Nutrition by Regions and Rural/Urban.

States	Percentage of urban population receiving a diet inadequate in calories.	Percentage of rural population receiving a diet inadequate in calories.
1. *North-West* (Punjab, Haryana, U.P., Rajasthan, Gujarat)	39	17
2. *East* (Bihar, Orissa, West Bengal, Assam)	44	42
3. *South* (Andhra Pradesh, Kerala, Tamil Nadu)	69	65

Source: Adapted from Tables 1.5 and 1.6 in V. M. Dandekar and Nilkantha Rath's *Poverty in India,* (Bombay: Indian School of Political Economy, 1971) pp. 9-11.

TABLE 25

Diets of Pre-school Children (in grams)

Item	Intake per head per day	Recommended amount
1. Cereals	162	175
2. Pulses	10	50
3. Fresh Foods	5	15
4. Milk and milk products	57	238
5. Fats and oils	3	23
6. Leafy vegetables	2	63
7. Other vegetables	10	40
8. Fruits	7	50
9. Sugar and 'gur'	6	37

Source: C. Gopalan, *et al. Diet Atlas of India,* 1971.

TABLE 26

Intake of Nutrients in Selected Urban Areas—School Age Children

	Pre-School Children (1–5 years)		School Children (6-12 years)	
	Calories	Proteins (gms)	Calories	Proteins (gms)
Gujarat[1]	869	24.6	1535	46.7
Maharashtra[1]	614	19.5	1161	33.9
Karnataka[2]	456	17.3	803	26.2
Tamil Nadu[2]	672	21.7	1114	29.8
Andhra Pradesh[2]	520	14.5	859	23.7
Kerala[2]	648	18.8	1083	26.3
Calcutta[3]	804	22.5	1188	36.5
Hyderabad[4]	758	19.5	1377	36.0
Recommended daily allowance (ICMR Standards)	1350	19.3	1950	37.0

1 Food Habits Survey, PFA 1969, Maharashtra and Gujarat.

2 Food Habits Survey, PFA 1971, 4 Southern States.

3 Survey Report on Calcutta Food Habits 1970-71, Hindustan Thompson Associates.

4 ICMR Studies on Diets of Pre-School Children, NIN, Hyderabad.

Source: Margaret Burns Parlato—*Nutrition Consumer Research-An Exploratory Study*, CARE—India, March 1973, as reproduced in *Statistical Profile of Children & Youth in India*, UNICEF, October, 1974.

TABLE 27

Statement showing Progress of the Applied Nutrition Programme upto March 31, 1973 (provisional)

States/Union Territory	Villages taken up (No.)	Pre-School children fed (000, child-days)	Expectant/ Nursing Mothers fed (000 ,women-days)
1 Andhra Pradesh	758	3,293	954
2. Assam	1,962	381	7
3 Bihar	2,547	265	19
4. Gujarat	805	16,275	354
5. Haryana	1,903	174	94
6. Himachal Pradesh	2,913	543	73
7. Jammu & Kashmir	3,017	NA	—
8. Karnataka	7,870	2,050	40
9. Kerala	915	1,50,452	32,483
10. Madhya Pradesh	5,248	2,240	402
11. Maharashtra	1,029	3,682	361
12. Manipur	1,319	13	3
13. Meghalaya	163	300	26
14. Nagaland	—	—	—
15. Orissa	9,510	16,793	435
16. Punjab	4,222	1,424	857
17. Rajasthan	2,978	1,064	145
18. Tamil Nadu	877	4,235	586
19. Tripura	99	1	—
20. Uttar Pradesh	40,617	2,822	459
21. West Bengal	2,234	1,121	137
22. Andaman & Nicobar	—	—	—
23. Arunachal Pradesh	—	—	—
24. Chandigarh	—	—	—
25. Dadar & Nagar Haveli	70	—	—
26. Delhi	78	21	—
27. Goa, Daman & Dieu	159	93	—
28. Lakshadweep	—	—	—
29. Mizoram	—	—	—
30. Pondicherry	148	10	1
ALL INDIA	91,441	20,72,438	37,435

Source: Report 1973-74, Ministry of Agriculture, Department of Community Development, Government of India.

TABLE 28

Statement showing the year-wise coverage of Special Nutrition Programme and Balwadi Nutrition Programme—All India 1970–71 to 1973–74.

Year	Special Nutrition Programme						Balwadi Nutrition Programme	
	Number of beneficiaries covered (in lakhs)			Number of Feeding Centres			Number of Balwadis	Number of beneficieries covered
	Urban	Tribal	Total	Urban	Tribal	Total		
1970-71	3.31	3.24	6.55	1465	4471	5936	470	19280
1971-72	10.56	10.82	21.38	4900	12800	17700	5577	220640
1972-73	16.97	18.03	35.00	7211	19003	26214	5577	220640
1973-74	18.15	18.81	36.96	8128	19344	27472	6059	229016

Source: Report 1973-74, Ministry of Education and Social Welfare, Department of Social Welfare, Government of India.

CHILD EDUCATION

CHAPTER : IV

"In assigning a label to seventh decade of the twentieth century, historians will have a wide range of descriptive terms from which to choose. Within the field of education, however, the choice would hardly be a difficult one, for it has most assuredly been the decade of the young child, especially the disadvantaged child".

—Bettye Caldwell

Status of Child Education : Primary Education

The Directive Principle contained in *Article 45* of the Indian Constitution, adopted in 1950 reads:—

> "The State shall endeavour to provide within a period of ten years from the commencement of the Constitution, free and compulsory education for all children until they complete the age of 14 years."

Apart from being a Constitutional obligation the provision of universal elementary education is considered crucial for spreading mass literacy, which is a basic requirement for economic development, modernisation of social structure and effective functioning of democratic institutions. It also represents an indispensable first step towards the provision of equality of opportunity to all its citizens.

For various reasons—shortage of resources being the major one—the objective of free and compulsory education for all children up to 14 years has not been fully achieved. During the Third Five Year Plan, a slightly limited target of covering all children between 6 and 11 years of age was accepted. But

the figures of school enrolment indicate that although there has been a substantial increase in school enrolment during the last two decades, even this limited target remains to be achieved (Table: 29). As regards universal provision of school facilities, the target has been more or less achieved at the lower primary stage where all villages with a population of 300 or over have been provided with schools. According to the Second All India Educational Survey (1967), 95.96 per cent of rural population was served with primary schools in their own habitation or within a walking distance of one mile.[1]

School Enrolment

The enrolment position of 6-14 age group in class I–VIII as anticipated in 1973-74 and with projections for 1978-79 is illustrated in Chart: 16. It reveals that although substantial progress was recorded in the expansion of educational facilities, the targets laid down for primary education were not fully realised. The shortfalls have been particularly large in the case of elementary education of girls. There are wide variations from region to region (varying from 100 per cent in some parts of the country to as low as 27 percent in others), and the States of Andhra Pradesh, Bihar, Karnataka, Madhya Pradesh, Maharashtra and Orissa have particularly lagged behind.

Similarly, if we examine enrolment figures for corresponding age groups for all areas i.e. urban and rural, it is evident that the enrolment is much higher in urban areas. According to available figures, of the 85.6 million children now in primary and middle schools, only 45.24 million are rural children. This figure looks even worse when compared to the total rural child population of 187.67 million.

The nationwide school enrolment of girls in the 6-11 age group is estimated to be 66.4 per cent, as against 100.2 per cent for boys. But in 11 to 14 range, only 22 per cent of the girls are at school and the vast majority of them is from 20.53 million girls in the urban child population (Chart: 17).

Enrolment apart, most of our schools are a national disgrace. Of the 547,672 villages in the country, 294,880 have schools; 203,240 have a school within 'walking distance' —48,566 villages are not served by any school. Even where there are schools, what sort of schools are these? In the whole countryside, 167,382 rural schools are functioning with one teacher a piece. More than a quarter of the schools (103,811) are classed as 'incomplete schools'—they go only up to Class III. Their students have to go elsewhere—if they can for pursuing 'higher study'. Very few of them do, and the rudimentary education is soon forgotten as the helpless child gets sucked into the rural labour force.

Wastage and Stagnation

Even more crucial than the shortfall in enrolment at the primary stage is the problem of wastage and stagnation. At present out of every 100 children who enter class I less than half the number complete Class V and only 24 complete Class VIII. The dropping out of the educational stream of more than 60 per cent of children (Chart: 18) before completing 4 to 5 years of schooling, represents a colossal wastage of scarce national resources. The rate of drop-outs in case of girls is still worse. Of every 100 girls enrolled in class I, only about 30 reach Class V.

The causes of wastage and stagnation at the lower-primary level include continuous admissions throughout the year, irregularity of attendance, limited educational equipments, over-crowded classes, inflexible curricula, inadequate training of teachers and over-emphasis an examination. The causes of stagnation and wastage in higher primary classes of V to VIII, however, are mostly economical, social and educational. About 65 per cent of wastage has been attributed to poverty and economic reasons.[3] After the age of 9 or 10 the child becomes an economic asset as he can supplement the family income. It has been noted that the number of dropouts is generally higher in slum areas, drought-prone villages and

among marginal families. In some occupational groups e.g. sweepers, washermen, artisans children are usually engaged in the family occupation. Frequent interruptions in schooling adversely affect children's performance and they often leave schools.[3]

In some cases, the impediment is not poverty but neglect by parents. Education of girls is not valued equally, since she is not expected to earn a livelihood. In times of family crisis, a girl would be expected to stay at home and help the mother in household chores. There is no estimate of the vastly large number of rural girls who drop out of school to take over household duties. There is also no estimate of rural girls—and even boys-doomed to child marriage.

The educational reasons, such as the high pupil-teacher ratio, overcrowded and inadequate physical facilities, lack of occupational bias in education, shortage of qualified staff and lack of ancillary services of mid-day-meals, school uniforms and school health discourage students from maintaining their interest in schools. The slow-learners and those who fail to be promoted to the next class at the end of the year often swell the ranks of dropouts. It has been observed that the first generation literate children become slow-learners and eventually drop-out as no supportive services are availbable at home. Teaching techniques are also dys-functional. Recitation, copying, drill and examination are accepted as necessary evils. The teacher is poorly equipped and more often poorly motivated.

Thus on the whole, while the quantitative expansion of primary education seems to have proceeded at a reasonable pace, it is the poor quality which seems to have caused greatest concern among educational planners and administrators. The sheer number of children and teachers involved tend to paralyse most efforts at qualitative improvement of primary education. There are isolated instances of experimental

projects directed at qualitative improvement of education. But these efforts do not appear to have made sufficient impact so far. The many attempts to integrate the school with the community have also failed because the school with its fixed time table and schedule is of dubious value to the community.

Pre-school Education

The importance of pre-school education is universally recognised as catering to the most plastic, impressionable and educationally potent period of a child's life. There is sufficient research evidence to show the crucial importance of the first six years of the child's life in his physical, emotional, social, cultural and intellectual development and the retardation likely to result due to deprivations in his physical and social environment, during this period of his life. Recent physiological studies indicate that 40 per cent of brain growth is completed by the age of four and 80 per cent by the age of eight, and that lapses in health, growth and development in the early years are irreversible.

Child specialists and professionals are becoming increasingly concerned with and about early care of the child. Such a concern is a consequence of not only of awareness of the increasing need but also the mounting appreciation of the importance of the environment of the child during the first formative years on his subsequent development. The need for pre-school education is considered more pronounced in the case of children from culturally and socio-economically disadvantaged homes. The majority of Indian parents, as is well known, are unable to give much of a stimulation to their children because of their poverty, illiteracy or semi-literacy (Chart: 15) and are not able to contribute much to their children's physical, cultural and cognitive development.

The lack of pre-school education is also considered to be closely linked to the problem of wastage and stagnation in primary school. More than 90 per cent of India's children go

to the primary school at the age of 5 or 6 without having had any kind of preparation for schooling. Their vocabulary is limited, concept formation is poor and they are not used to working in groups. When the child enters primary school he is ill-at-case in his body, and limited in mental faculties. He lacks self confidence. School is a foreign land, where the child feels transplanted, labelled as inadapted, with no prior training to read, write or count, or to behave as a socially-integrated being. He either stays down in the lower class or drops out of the educational stream.

Though pre-school education has been rapidly gaining in popularity in the post-Independence period, only a fraction of the total population of 3 to 5 year-old in India is getting an opportunity to attend a pre-school institution. It has been estimated that about 1.2 million children participate in some form of pre-school education.[4] However, disproportionately very few of these children are from the disadvantaged sections. Few of the children of rural and urban working mothers, belonging to underprivileged sections of population, recieve even minimal institutional care services.

The pre-school education programme is organised in institutions called by different names e.g. kindergartens, Montessori schools, pre-primary schools, nursery schools, pre-basic schools, balwadis, shishu vihars etc. The first large scale attempt to provide pre-school services for rural children came up with the setting up of balwadis in the 1950's under the initiative of the Central Social Welfare Board. There are now about 20,180 balwadis in the rural and urban areas run by voluntary organisations with financial support from or directly run by the Central Social Welfare Board, Departments of Social Welfare and Community Development. This network reaches out to about 650,000 children in the country.

Besides the Government-supported network, there are a large number of private institutions providing pre-school education. These institutions are attached to primary schools,

under private management, operated by voluntary groups or run by individuals on a commercial basis. Their number in 1968 was estimated to be 12,000 in urban areas catering to roughly half a million children.[5] Because of high fees charged by these institutions, these are outside the reach of pre-school children coming from lower income groups.

The approach in pre-school education institutions varies between different degrees of education and care. In some cases they are no more than a means of getting the children together for the feeding programme, specially in the case of balwadis run by Mahila Mandals and other community organisations. Similarly, the training and qualifications of staff also vary considerably. The urban-based privately organised pre-school institutions also have varying standards of building, equipment, staff and programme-content.[6] As there is no official recognition of pre-primary education nor any minimum standards laid down, there is no monitoring system for enforcing such standards.

Thus, the existing pre-school programmes are either conducted indifferently by most private and official agencies and are limited to providing custodial care where children are washed, dressed and fed and made to sing or listen to stories, or are treated as extensions of primary school programmes where children sit in rows and learn the three Rs. Attendance at these institutions, especially at balwadis, tend to be irregular and there are frequent interruptions in nutrition on account of weaknesses in food procurement, storage and transportation and lack of cooking facilities.

In India pre-school education has been bracketed with social welfare. In terms of quantitative coverage as well as quality, the position is far from satisfactory. The picture that emerges is of a growing awareness of the need, a skeletonic framework of services and an evolving policy in relation to the limitation of resources–financial, human and material. There

has as yet been no official acceptance by the state of its responsibility and hence no significant allocation for pre-school programme in the country.

The real importance of pre-school education is rarely understood by the traditional, illiterate mother. Her conception of pre-school education is limited to formal reading, reciting and writing. Her motive in sending the child to a pre-school institution may also differ; it may be a question of prestige, it may be because it gives her a little more leisure, or it may be because it takes care of the child while the mother is away at work. From several small-scale studies, evidence is available showing that a majority of parents conceive of a balwadi as a place for formal learning rather than an opportunity for creative learning and over-all development of the child.[7]

With regard to the benefits of pre-school education, research evidence is available that given environmental stimulation through pre-school education, it is possible to give children a better start in life and a better chance of higher achievement in later life. A large scale study conducted by the National Council of Educational Research and Training revealed that rural children, who could not attend a pre-school were much inferior in their developmental level e.g. number concept, colour naming, image-formation and other tasks related to school readiness, when compared to urban nursery school children.[8] However, results are contradictory in so far as the question of permanency of these benefits is concerned. There is little data pertaining to the long-range stability of early educational experiences. What we need is continuous, ongoing evaluation of pre-school programmes, to help us determine their relative effectiveness.

By way of conclusion it can be said that the need for expansion and qualitative improvement of pre-school education has been well recognised but the problem is one of finding resources. Priorities must hence be laid down. The pre-school must be conceived as the organisational base for health

care and health education, nutrition, and education of mother so as to ensure effective delivery of services.

Primary Education: Programmes and Services

According to the Directive Principle contained in Article 45 of the Constitution, free and compulsory education should have been provided for all children upto the age of 14 years by 1960. In spite of considerable expansion of primary school facilities in the country this directive has remained unfulfilled because of the immense difficulties including lack of adequate resources and other socio-economic factors.

India's effort in the field of primary education has been summed up as follows:[9]

- Is there a primary school? If not, start one within easy distance from the home of every child (provision of primary schools).
- Get everybody into it at the right age (efforts for solving the problems of child labour and girls education).
- Once a child gets into a school, he or she should not be taken away before attainment of proper age (tackling the problem of wastage).
- While a child is at school, he should complete one calss every year (lowering the incidence of stagnation).
- Provide the knowledge which keeps pace with the scientific and technological changes and development of the country (qualitative improvements in school curriculum).
- Let the school be a place which ensures not only his mental growth but his physical and over-all development (provision of health and nutrition programmes).
- The educational system must produce the type of individual the country needs (reorientation of the educational system).
- Let education get its fair share of the country's resources (financial allocations).

The *Second Five Year Plan* (1956-61) observed that the goal set in the Constitution for free, compulsory and universal education for children between 6-14 years of age was not achieved and resolved to accelerate efforts so as to achieve the target within ten to fifteen years. The plan stressed the need to enhance the rate of enrolment of girls.

The *First All India Education Survey* (1957-59), appointed by the Ministry of Education, Government of India, made a detailed assessment of the country's educational needs and suggested a plan to rationalise the location of primary schools in the country. The survey proposed a school only at places with a minimum population of 300 so that 40 children could be enrolled and at least a single teacher school could be established. Similarly, the walking-distance for a child in rural areas in the age-group 6 to 11 for attending the school was fixed at about one mile.

The *Second All India Education Survey* (1967) revealed that in almost all the states, villages with a population of 300 or over and sometimes even smaler villages were provided with schools; 94.96 per cent of rural population was served with primary schools in their own habitation or within a walking distance of one mile. Enrolment in Classes I to V increased from 35 million in 1960-61 to 55.5 million in 1968-69, and in Classes VI to VIII, it increased from 6.7 million to 12.3 million. Yet, the *Fourth Five Year Plan* (1969-74) observed with concern the delay in complying with the Constitutional Directive. The recommendations of the Education Commission (1966) formed the basis of the National Policy on Education and provided a framework for the formulation of plan programmes. The Commission had stated that while the Constitutional Directive would be fulfilled in some places such as urban areas or educationally advanced states as early as in 1975-76, all the areas in the country should be able to provide five years of good and effective education to all children by 1975-76 and seven years of such education by 1985-86.

A review of the Fourth Plan performance in this field suggests that although substantial progress was recorded in the expansion of educational facilities, the targets laid down for elementary education were not realized in full as illustrated in Table : 33. It may be seen that the shortfalls have been particularly large in the case of girls.

During the Fourth Plan period, a number of schemes were initiated for improving elementary education e.g. establishment of three printing presses for the publication of nationalised text books, provision of science equipments with the assistance of the UNICEF to all training institutions and a number of selected schools, training of science teachers in the improved curriculum, preparation of teachers' manuals etc. Pilot projects were launched by state Governments in selected areas to reduce the incidence of wastage and stagnation. Similarly, programmes of curriculum improvement and examination reform were initiated by the NCERT and the State Boards of Education.

The *Fifth Five Year Plan* (1974-79) has proposed that full time primary school facilities will be provided for 97 per cent of the children in the age-group 6-11 and 47 per cent in the age-group 11-14 by the end of the Plan. This will mean the creation of additional facilities for 145 lakh children in Classes I to V and 66 lakhs in Classes VI to VIII. In addition, about 78 lakh children of the age-group 11-14 will be provided part-time education. If these enrolment targets are realised in full, it should be possible to fulfil the Constitutional obligation by the end of the Sixth Five Year Plan.[10] However, it has been conceded that some regional disparities may continue, particularly in respect of the enrolment of girls and children of the Scheduled Castes and Scheduled Tribes. State-wise position in regard to elementary education, is given in Table: 32. The table reveals that the shortfalls have been particularly large in the states of Andhra Pradesh, Bihar, Orissa, Madhya Pradesh, Maharashtra and Rajasthan.

Girls Education

Although there has been a large scale expansion of elementary school facilities for girls, disparities still exist in the relative utilisation of available facilities by boys and girls at various stages of elementary education, as illustrated in Table : 31. The Fifth Plan has made provisions for increasing the supply of women teachers by giving scholarships to the local girls, organising condensed and correspondence courses, and re-orienting the curriculum to meet girls' special needs and requirements.

Measures for preventing wastage and stagnation

Since most of the children, who dropout or are withdrawn from schools prematurely, do so mainly for economic reasons, it has been accepted that given the present level of *per capita* income, it would be unrealistic to expect that the problem of dropouts can be completely solved in the near future. In the meantime, certain important measures have been proposed to reduce the incidence of wastage and stagnation. A '*multiple entry*' system would be introduced at the primary school stage enabling the children to get education at the time most convenient to them and their parents. Under this system, children above 10, who drop-out after the first year or two, would be taken in special part-time classes which would make them *functionally literate*. This would ensure that children of one age-group do not sit with others of lower one and lose interest in their studies. After the *special classes*, these children would be given education in Class V.

Another facility to be provided to the grown-up children, who cannot be full-time student is part-time primary education. Yet another feature to be introduced will involve the utilisation of *local talent* of the community in the teaching of subjects like music and crafts. Efforts would be made to relate school curriculum to the environment. Similarly, the school terms would be adjusted to the harvesting and sowing seasons.[11]

The Fifth Plan proposes to lay much greater emphasis on improving the quality of primary education, particularly with a view to enhancing the efficiency and productivity of the schools. Curricular reorientation, adoption of appropriate teaching methodologies, improving the teachers' competence through pre-service and in-service training programmes, expanding basic physical facilities and strengthening educational administration at the district level are some of the measures directed at qualitative improvement of primary education. It has been postulated that social justice and national productivity would both be served with the universalisation of elementary education through work-centred formal and non-formal education.

Pre-School Education: Programmes and Services

The beginning of efforts for providing pre-school education can be traced back to 1885 when missionary organisations pioneered the efforts for providing pre-school education by opening kindergartens in Lucknow and Poona. In the early 20th Century, theosophists and other private agencies organised efforts to popularise pre-school education. The influence of Tagore and Annie Besant also contributed towards spreading the movement and, consequently, the ten years between 1920 and 1930 witnessed a mushroom growth of many nursery schools throughout the country, particularly in South India. The arrival of Madame Montessori in India and her association with Mahatma Gandhi gave further impetus to the movement.

The programme, however, covered only the children coming from urban-based, well-to-do families, and under-privileged children of rural areas and urban slums were left unattended. Pre-school educational efforts for the latter category were initiated by Balkan-Ji-Bari, The All India Women's Conference, Guild of Service and the Indian Council for Child Welfare.

Governmental concern for the promotion of pre-school services is evident from the number of expert bodies set up by

the Government from time to time. *The Sargent Committee Report* (*1944*) was the first official document which highlighted the need for pre-school education to the disadvantaged children. The committee was bold enough to suggest that state should take up the cause of pre-primary education.

The *First Five Year Plan* (*1951*) pointed out the vulnerability of children in pre-school stage and pleaded for increasing activity on the part of local bodies to organise balwadis, especially in rural areas. The Government's role was confined to evolving suitable methods of pre-school education, training personnel and providing grants-in-aid to voluntary agencies for running balwadis in rural areas. The first large scale attempt to provide pre-school services for rural children came up with the setting up of balwadis in the 50's under the initiative of the Central Social Welfare Board.

The *Second Five Year Plan* (1956-61) stressed the need to intensify the efforts to popularise basic education programme. The constitution of a 'Child Care Committee' by the Ministry of Education and Central Social Welfare Board in 1960 for preparing a comprehensive plan for the young child (0–6 age-group) marked another milestone in the history of pre-school programme in India. The Committee examined the problems of pre-school child in depth and suggested long-term experimental projects for evolving comprehensive services for children. Development of the pre-school as a possible focal point for delivering various services for children was indicated and different models of pre-school programme were outlined. The Committee felt that the responsibility for starting pre-schools should be left to voluntary organisations with adequate assistance from the Government.

The *Third Five Year Plan* (1961–66) stressed the need to expand facilities for pre-school education. Improvement of existing balwadis, opening new balwadis and expansion of training programmes for balsevikas were the main schemes recommended for promoting pre-school education.

The Education Commission Report (1966) outlined the importance of pre-primary education particularly for children coming from urban slums and unsatisfactory home environments. The Commission set out a target of enrolment of 5 per cent of the children in the age-group 3 to 5 by 1985-86.[12]

The Committee on Programmes for Child Welfare (Ganga Saran Sinha Committee) was set up in 1968 by the Department of Social Welfare with the specific purpose of preparing a programme for child welfare. The Committee reviewed the recommendations of the Education Commission and felt that coverage of pre-school education programme should be accelerated to reach at 10 per cent of the age-group 3 to 5 in a period of 10 years beginning from 1969-70 and priority being given to children of vulnerable groups. To cover the desired percentage, the Committee felt that it was necessary to increase enrolment from 850,000 in 1965-66 to 36 lakhs by 1978-79.[13]

The *Fourth Five Year Plan* (1969-74) underscored the vital role of the voluntary sector in developing pre-school education in the country. The Government's area of operation was limited to certain strategic fields such as training of teachers, evolving suitable teaching techniques and production of instruction materials.

In 1972 the Ministry of Education and Social Welfare appointed a Study Group on the Development of the Pre-school Child. The Group spelt out the various needs and requirements of the pre-school child and emphasised the importance of providing integrated services covering education, health, nutrition and welfare for promoting the optimum physical, mental, emotional and social development of the pre-school child. Mobilising community support and involvement, employing local women in rural areas, maximum utilisation of institutional infra-structure, and adoption of a variety of models were important aspects of the Group's recommendations. The Group visualised coverage of 10 per cent of

children from families below the poverty line and are between 3 to 5 years of age (or 5 million children) by 1981.

During *the Fifth Five Year Plan* (1975-80) it has been envisaged that children's play centres for the age group 3–6 would be attached to selected primary schools. In addition, private agencies and voluntary organisations will be encouraged to start pre-primary schools and the State will further assist in strategic areas of teachers training, preparation of teacher guides and manuals, and promotion of research for evolving methods of pre-school education suited to our conditions. In some Integrated Child Development Services projects pre-school education will be introduced on an experiemental basis.[14]

From the above brief account it can be seen that pre-school education in India has moved in two parallel directions. As part of education, it has been left to private initiative with the Government taking practically no responsibility. As part of social welfare services, it has developed in a limited manner in the form of balwadis in rural and urban projects of the Government through the Central Social Welfare Board and Departments of Community Development.

Since Independence, importance of development of pre-school education programme on a viable scale has been recognised and various committees, commissions and study groups have suggested many appropriate measures to improve the programme qualitatively and quantitatively. But due to constraints on resources and other administrative difficulties, most of the recommendations could not be implemented. It is maintained that Government can assume only limited responsibilities in view of scarce resources and its commitment to the provision of compulsory primary education. The role of voluntary sector, on the other hand, in developing a variety of approaches and of the CSWB in building up a network of rural institutions has been commendable. As a result the number of pre-schools has risen from 303, with an

enrolment of 28,000 in 1950-51 to 3500 with an enrolment of 2,50,000. In addition, 20,000 balwadis, with a total enrolment of 600,000, are supported by the CSWB and Community Development Administration. There are 75 pre-primary teachers' training institutions in the country, though with varying standards of admission, content of programme and approach.

The experiments of the States of Tamil Nadu, Maharashtra and Rajasthan in the field of pre-school education deserve special mention. Tamil Nadu has successfully experimented with training of local women as pre-school teachers and allotment of free land by the village council for the construction of the balwadi, as a part of its low-cost and CARE supported pre-school care programme. As a result of development over the past decade, there are at present 1,443 balwadis at work. The State of Rajasthan launched another kind of experiment in 1970-71 of attaching pre-primary classes to primary schools. Similarly, Maharashtra has also initiated a programme of attaching pre-primary classes to primary schools and giving new orientation to teachers' training programme. At Kosbad, an institution has developed a new kind of structure called 'Vikaswadi—which is a creche, a balwadi and a primary school under the same roof. In Delhi, a chain of day-care centres has been established for the children of migrant construction workers on work sites providing an integrated programme of total care and education.

With the present limitation of resources, it is not possible to think in terms of extending pre-school education to all children in the near future. Ways and means are being evolved for making pre-school education inexpensive. Some of these measures are: (i) community involvement and participation; (ii) devising indigenous materials and play equipments; and (iii) training local women as balwadi teachers.

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Chart . 15

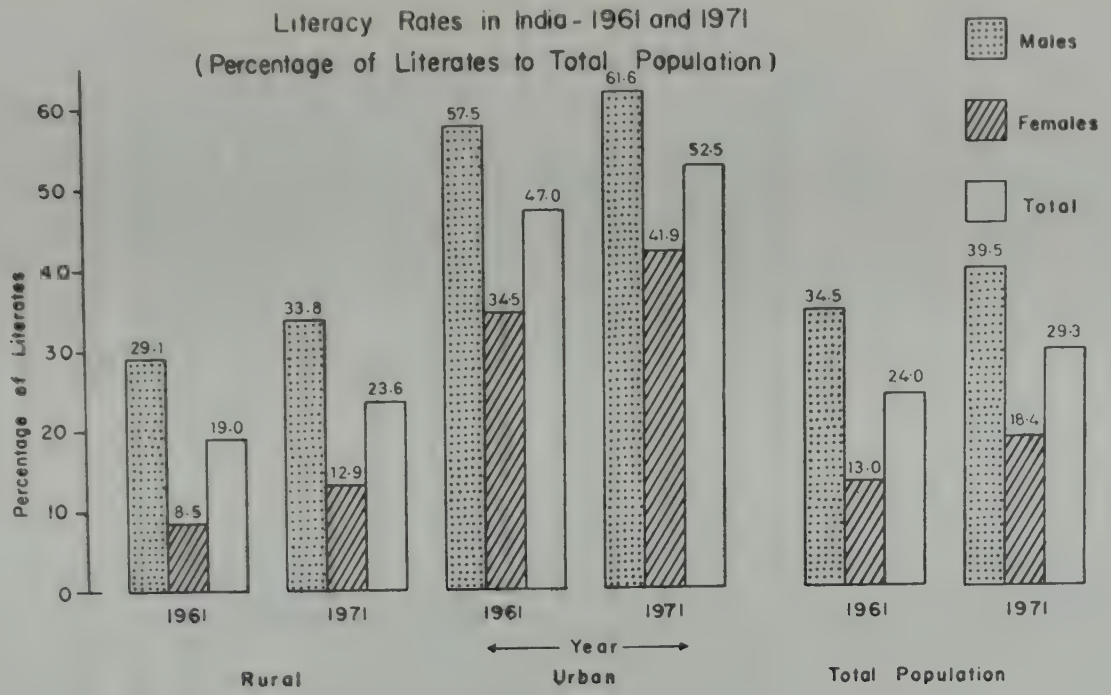
Literacy Rates in India - 1961 and 1971
(Percentage of Literates to Total Population)
Males
Females
Total
Percentage of Literates
60
50
40
30
20
10
0
29·1
8·5
19·0
33·8
12·9
23·6
57·5
34·5
47·0
61·6
41·9
52·5
34·5
13·0
24·0
39·5
18·4
29·3
1961
1971
1961
1971
1961
1971
Year
Rural
Urban
Total Population

Chart : 16

Enrolment of Children of the Age group 6-14 in Class I - VIII

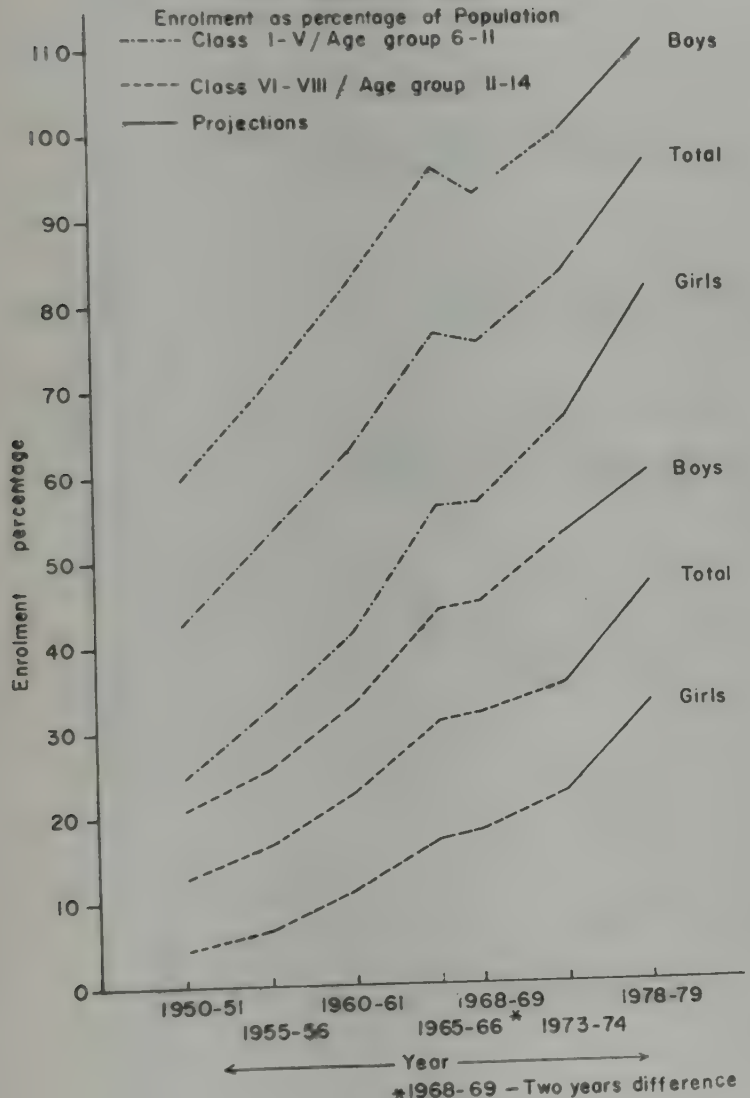

Chart : 17

Status of Child Education

Enrolment Targets and Achievements in the Fourth Plan

(Figures in Lakhs)

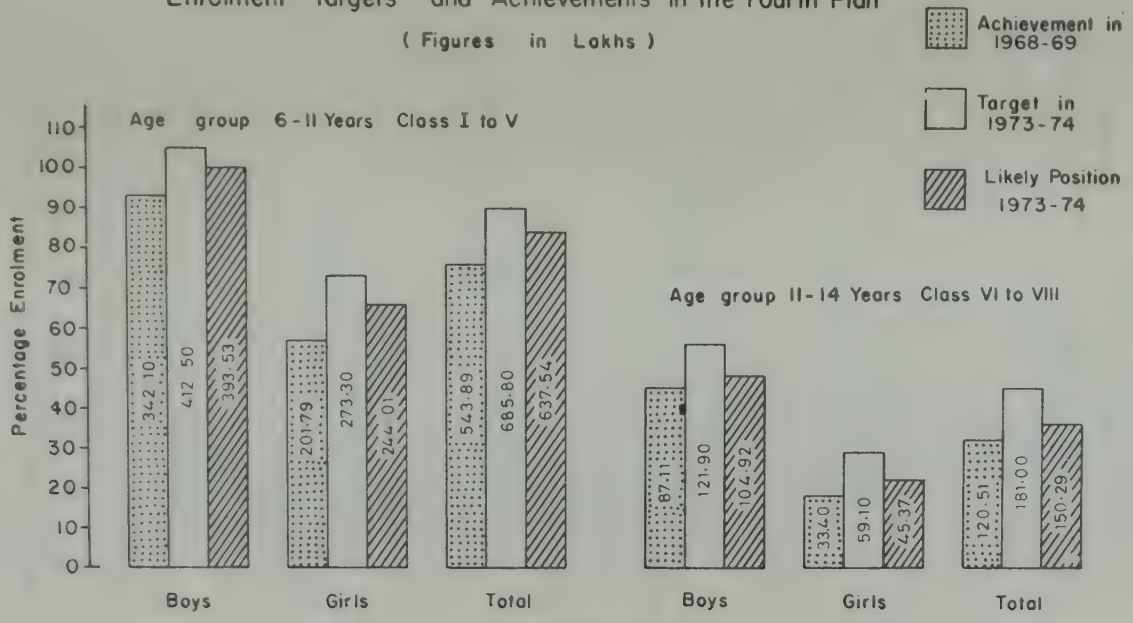

Chart : 18

Wastage at Primary Stage 1960-61 to 1964-65
Enrolment (in,000) in Class I to Class V

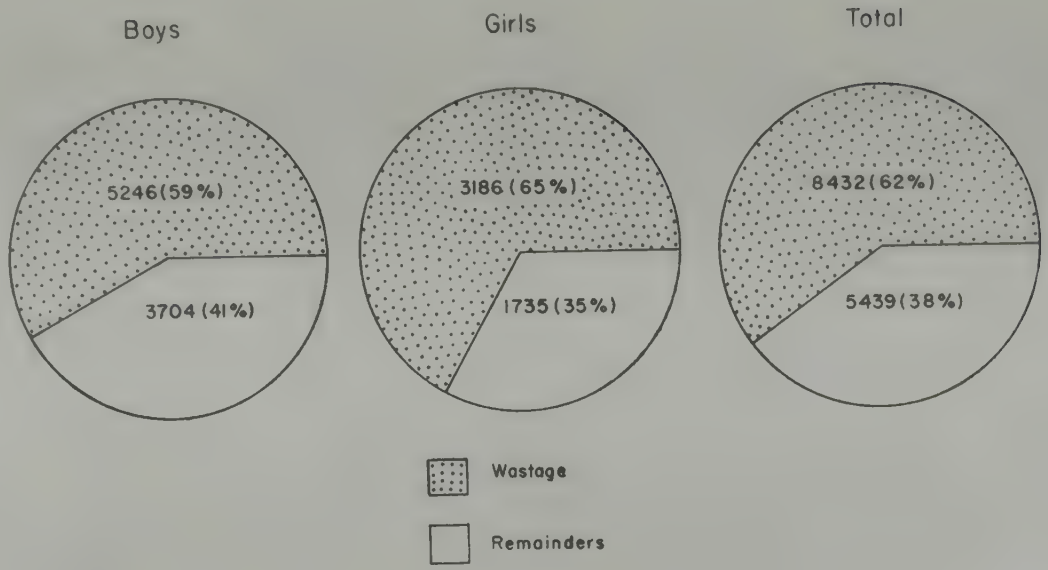

TABLE 29

Growth of Enrolment in School Education: 1968–69 to 1978–79

(*enrolment in thousands*)

Stage/Age Group	Total Boys/Girls	Position 1968-69	Anticipated Achievement 1973-74	Target 1974-75	Likely Position 1978-79 (Target)
Primary Classes	Total	54389	63754	69978	78207
I-V (6-11 years)	Boys	34210	39353	42531	46319
	Girls	20179	24401	27447	31888
Middle Classes	Total	12051	15029	17271	21580
VI-VIII(11-14 yrs)	Boys	8711	10492	11858	14326
	Girls	3340	4537	5413	7254
Elementary Classes	Total	66440	78783	87249	99787
I-VIII (6-14 yrs)	Boys	42921	49845	54389	60645
	Girls	23519	28938	32860	39142

Source: Annual Plan 1974-75, and Draft Fifth Five Year Plan 1974-79, Vo.. II Government of India, Planning Commission.

TABLE 30

Enrolment of Children of the Age-group 6–14 in Classes I—VIII

(*Enrolment as percentage of population in the age-group*)

	Classes I-V/age-group 6-11			Classes VI-VIII/age-group 11-14		
Year	Boys	Girls	Total	Boys	Girls	Total
1950–51	59.8	24.6	42.6	20.7	4.5	12.7
1955-56	70.3	32.4	52.9	25.5	6.9	16.5
1960-61	82.6	41.4	62.4	33.2	11.3	22.5
1965-66	96.3	56.5	76.7	44.2	17.0	30.9
1968-69	93.0	57.0	75.8	45.0	18.0	31.9
1973-74 (anticipated)	100.2	66.4	83.9	48.3	22.2	35.6
1978-79 (target)	111.3	81.9	97.1	60.4	32.8	47.1

Source: Draft Fifth Five Year Plan, 1974–79, Volume-II, p. 194.

TABLE 31

Expansion of Girl's Education

(*enrolment in millions*)

Year	I-V enrolment		Col. 2 as percentage of Col. 1	VI-VIII enrolment		Col. 5 as percentage of Col. 4
	Total	girls		total	girls	
0	1	2	3	4	5	6
1950-51	19.15	5.38	28.1	3.12	0.53	17.0
1955-56	25.17	7.64	30.4	4.29	0 87	20.3
1960-61	34.99	11.40	32.6	6.70	1.63	24.3
1965-66	50.47	18.29	36.2	10.53	2.85	27.1
1968-69	54.39	20.18	37.1	12.05	3.34	27.7
1973-74 (anticipated)	63.75	24.40	38.3	15.03	4.54	30.2
1978-79 (target)	78.21	31.89	40.8	21.58	7.25	33.6

Source: Draft, Fifth Five Year Plan Planning Commission, Government of India, 1974, p. 197.

TABLE 32

Sex-wise Enrolment (anticipated) in Classes I-V and VI-VIII during Fourth Five Year Plan by States/Union Territories

(Figures in thousands)

State	Total Enrolment Classes I–V			Total Enrolment Classes VI–VIII		
	Total	Boys	Girls	Total	Boys	Girls
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1. Andhra Pradesh	4300	2583	1717	670	465	205
	(76)	(89)	(62)	(30)	(42)	(19)
2. Assam	1866	1088	778	503	312	191
	(78)	(97)	(62)	(40)	(75)	(36)
3. Bihar	4856	3556	1300	1091	921	170
	(62)	(86)	(34)	(24)	(41)	(8)
4. Gujarat	3520	2187	1333	897	590	307
	(88)	(105)	(69)	(42)	(52)	(30)
5. Haryana	1050	750	300	400	303	97
	(69)	(94)	(41)	(50)	(72)	(25)
6. Himachal Pradesh	410	252	158	137	103	34
	(86)	(105)	(67)	(54)	(81)	(27)
7. Jammu & Kashmir	493	316	177	131	89	42
	(78)	(97)	(57)	(38)	(50)	(26)
8. Karnataka	3191	1813	1378	940	650	335
	(97)	(107)	(86)	(41)	(51)	(30)
9. Kerala	3665	1927	1738	863	470	393
	(124)	(128)	(120)	(78)	(84)	(73)
10. Madhya Pradesh	3832	2671	1161	764	579	185
	(65)	(88)	(41)	(23)	(34)	(11)
11. Maharashtra	6232	3736	2496	1664	1141	523
	(89)	(104)	(74)	(43)	(57)	(28)
12. Manipur	188	114	74	38	25	13
	(115)	(129)	(97)	(44)	(57)	(31)
13. Meghalaya	146	87	59	24	18	6
	(80)	(116)	(77)	(30)	(44)	(15)
14. Nagaland	71	45	26	21	14	7
	(100)	(115)	(81)	(52)	(66)	(36)

15. Orissa	2038	1323	715	380	271	109
	(67)	(86)	(48)	(23)	(33)	(13)
16. Punjab	1840	1034	806	549	343	206
	(90)	(97)	(82)	(51)	(58)	(42)
17. Rajasthan	2490	1795	695	640	500	140
	(66)	(91)	(38)	(31)	(47)	(14)
18. Tamil Nadu	5426	3059	2367	1433	918	515
	(110)	(121)	(98)	(50)	(62)	(37)
19. Tripura	187	110	77	48	29	19
	(77)	(88)	(66)	(40)	(47)	(33)
20. Uttar Pradesh	11912	7305	4607	2237	1804	433
	(100)	(117)	(81)	(33)	(52)	(14)
21. West Bengal	5141	3093	2048	1240	781	459
	(80)	(94)	(60)	(35)	(43)	(27)
22. Andaman & Nicobar Islands	18.28	9.78	8.50	5.49	3.25	2.24
	(125)	(125)	(125)	(74)	(81)	(66)
23. Arunachal Pradesh	31.60	22.60	9.00	4.80	3.20	1.60
	(50)	(70)	(31)	(14)	(18)	(9)
24. Chandigarh	32.10	17.70	14.40	13.60	7.50	6.10
	(83)	(80)	(85)	(67)	(65)	(69)
25. Dadra & Nagar Haveli	8.50	6.00	2.50	1.15	0.80	0.35
	(78)	(111)	(45)	(22)	(32)	(13)
26. Delhi	574	322	252	263	154	109
	(94)	(100)	(88)	(80)	(88)	(71)
27. Goa Daman & Diu	130	74	56	39.50	23.50	16.00
	(113)	(122)	(104)	(62)	(71)	(52)
28. Lakshadweep	5.35	2.74	2.61	1.40	1.04	0.36
	(119)	(124)	(114)	(61)	(87)	(33)
29. Mizoram	32.00	16.50	15.50	10.00	5.50	4.50
	(73)	(75)	(71)	(39)	(41)	(36)
30. Pondicherry	68.40	37.80	30.60	20.60	12.60	8.00
	(121)	(128)	(111)	(67)	(80)	(53)
Total: INDIA	63754.23	39353.12	24401.11	15029.54	10492.39	4537.15
	(84)	(100)	(66)	(36)	(48)	(22)

Note:— Figures in parentheses indicate percentage coverage of the population in the corresponding age-group.
Source: Adapted from Draft Fifth Five Year Plan (1974-79), Government of India, Planning Commission, Vol. II, pp. 208-211.

TABLE 33

Enrolment Targets and Achievements in the Fourth Plan

(figures in lakhs)

Age-group/Classes	1968-69	1973-74 (target)	1973-74 (likely position)
6–11/I to V			
Boys	342.10 (93)	412.50(105)	393.53(100)
Girls	201.79 (57)	273.30 (73)	244.01 (66)
Total	543.89 (76)	685.80 (90)	637.54 (84)
11–14/VI to VIII			
Boys	87.11 (45)	121.90 (56)	104.92 (48)
Girls	33.40 (18)	59.10 (29)	45.37 (22)
Total	120.51 (32)	181.00 (45)	150.29 (36)

Note:— Figures in parentheses indicate enrolment as percentage of the population of the relevant age-group.

Source: Draft Fifth Five Year Plan, 1974-79, Vol. II, p. 191.

TABLE 34

Literacy Rates in India—1961 to 1971

(Percentage of literates to total population)

Year	Total Population			Rural			Urban		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
1961	34.5	13.0	24.0	29.1	8.5	19.0	57.5	34.5	47.0
1971	39.5	18.4	29.3	33.8	12.9	23.6	61.6	41.9	52.5

Source: Ashish Bose, Studies in India's Urbanization—1901-1971.

TABLE 35

Wastage at Primary Stage 1964–65

	Enrolment (in ,000) in Class I (4 to 5 years before)	Enrolment (in ,000) in Class IV/V (during the year)	Wastage (in ,000)	Percentage Wastage
Boys	8950	3704	5246	58.6
Girls	4921	1735	3186	64.7
Total	13871	5439	8432	61.8

Source: Education in India, 1964-65, p. 55.

CHAPTER V

CHILD WELFARE

"But somehow the fact that ultimately everything depedns on the human factor gets rather lost in our thinking of plans and schemes of national development in terms of factories and machinery and general schemes. It is all very important and we must have them, but ultimately of course, it is the human being that counts, and if the human being counts, well, he counts much more as a child than as a grown-up."

—Jawaharlal Nehru

Status of Chind Welfare

The term child welfare is used to denote the total well-being of children. It signifies programmes which benefit children and incorporates measures which promote environmental conditions congenial to children's healthy development, which prevent whatever may be detrimental to them, and protect them from harm and help overcome obstacles to the fuller development of their individual potentials. Child welfare, therefore, stands to mean a collection of activities which improves economic, social and cultural environment of children and provides services for promoting and protecting their well-being, preventing them from getting into all kinds of maladjustments and curing and rehabilitating them when handicapped.[1]

Since the child is relatively inaccessible, dependent upon mother's acceptability of services, efforts are needed to be directed towards mothers or families as a whole. One of the important responsibilities of the community and the State is to assist the family in every way so that it can fulfil its natural obligations towards the welfare of children.

Need for Supportive Services for the Family

The child is a product of social environment and for him family is a primary social group where he seeks love and affection, comfort and security and the fulfilment of his basic physical, emotional and psychological needs. An orphaned, destitute or delinquent child is a victim of broken or uprooted home or unhealthy social evironment depriving him of physical and social security. The transition from joint family system to nuclear type of family, the rising cost of daily necessities and various other economic and social compulsions are impelling mothers to take to gainful employment, part-time or full-time, to supplement the family income. A large number of families, both in rural and urban areas of the country, are below the poverty line and require substantial support and assistance from the Government and other outside agencies. The need for supporting services by way of creches, balwadis and day-care centres is increasingly being felt in industrial as well as rural areas by families where both father and mother are required to work outside home for long hours.

Though there has been a substantial increase in the volume of child welfare services in the country, most of the welfare programmes in the past were mainly designed with the objective of providing assistance to individuals and groups, who, on account of certain handicaps, could not take advantage of the amenities and services for the community in general. These services were largely curative and ameliorative in nature. The preventive and developmental aspects of social welfare, which are far more effective in the long run, could not receive adequate attention.

As far as welfare needs of children are concerned the CSWB was charged with the responsibility of promoting child care services in the country by strengthening voluntary action in this field through its massive grants-in-aid programme and other technical services. But an analysis of voluntary organisations, supported by the CSWB, reveals that these organisations are largely concentrated in big towns, cities and

metropolitan areas. There are very few voluntary organisations catering to the needs of children in rural, tribal and backward areas.[8] A few national level voluntary organisations e.g., Indian Council for Child Welfare, Bhartiya Adim Jati Sevak Sangh, Harijan Sevak Sangh and Bhartiya Gramin Mahila Sangh have tried to maintain a skeletonic child welfare service-structure. When compared to the magnitude of the problem, the total voluntary effort in the field of child welfare, has been negligible.

The efforts of the government, on the other hand, were mainly directed towards experimentation of services, provision of institutional support and coordination of activities in the field of child welfare. While successive five year plans have consistently emphasised the importance of promoting child welfare services, an element of inconsistency and strictly sectoral approach can be noticed. Experience of organising child care and welfare services under different sectors, during early plan periods, reveals that this was not the effective method of carrying services to various target groups. Unintegrated and sectoral approach also involved unnecessary duplication of effort and considerable waste of precious resources.

Recreational Needs of Children

Proper and adequate recreation is considered vital for the over-all development of the child. Healthy forms of recreation are instrumental in character-building among children; promote team spirit, cooperation and a sense of social responsibility, besides providing facilities for creative expression. Recreational services needed for children are provision of a wide range of facilities for indoor and outdoor activities such as playgrounds, parks, hobby centres, creative arts and films, dramatics, dance, music, hiking, swimming, nature study, etc. All these important needs are very inadequately recognised in India. The facilities for organised recreation available in urban as well as rural areas have been found woefully inadequate and the attitude of the community to provision of recreational

facilities for children generally apathetic.[3] Central and State governments and local bodies have assumed very limited responsibility for providing recreational facilities to children. Some of the voluntary organisations, such as the Indian Council for Child Wellfare, Balkan Ji Bari, Bharat Scouts and Guides, Kishore Dal and Bal Anand Sangham, have made efforts in this direction but the coverage of their services is very limited.

The provision of children's literature and libraries in the country is also very inadequate. The Ganga Saran Sinha Committee observed that there was hardly any separate library for children. Even in general libraries, very few had a children's section.[4] Consequently, children are exposed to commercially produced comics, literature full of horrors, violence and other undesirable contents. With regard to children's films some efforts have been made by the Children's Film Society to produce films for children. But its work has been of a very limited nature and has not been able to offer any viable alternative to commercial films.

The movement to start a chain of Bal Bhawans, Children's Theatres and Children's Museum is still in its infancy and only few metropolitan towns have these facilities. It is not possible to have such prestigious institutions, with elaborate facilities and expensive equipments, all over the country, at least not so many that they can reach the millions of ill-provided children in the country. To reach the children in towns and villages, and in the more congested and crowded areas of cities, the need is to start small recreation centres, in an inexpensive way, manned and managed by the neighbourhood itself.

Children in Distress—The Working Child

To any one who observes the Indian scene, one of the most disturbing facts is that most young persons who should be at school, are at work. Millions of children are working

long hours and constitute not a negligible part of the labour force in agricultural and industrial sectors; in fields, quarries, mines, plantations, factories, shops, offices and households.

According to 1971 Census, there were about 10.7 million children, out of 228 million in the age group 0-14, who were employed in some job or the other.[5] Of these about 7.9 million were boys and 2.8 million girls. Child workers thus constituted nearly 6.1 per cent of the total working force and about 4.7 per cent of the children under 14 years (Tables 36-38). These figures fail to give a complete picture since much of the employment of children is not reported. This is especially true of the unorganised sector of industry.

On the basis of figures on school enrolment and employment, a rough estimate can be made of children between 6 and 14 years, who were niether at school nor reported as workers. Out of 115 million children in the age group 6-14 the reported number of children enrolled was 75.5 million and those reported as employed 10.7 million. This leaves out roughly 28.8 million children of 6-14 age group whose activity status remains unspecified. A further computation indicated that by and large these were girls most probably engaged in domestic chores.

Children who are employed at a very early age are not only forced to carry out activities which are beyond their physical capacity or are exploited by unscrupulous employers, but are also deprived of education, recreation and rest which are basic to their growth and development. Although the employment of children in large-size factories is banned under the Factories Act 1948, in small scale and cottage industries such as bidi making, match factories, mechanical workshops, eating places and domestic occupations their employment is sizeable. Most of them are exposed to environment which is not conducive to their growth as normal children. Besides, the implementation of laws, protecting the interests of children in factories, mines, and plantations, has not been satisfactory due to inadequacy of inspection machinery and many children are,

therefore, exposed to hazardous and unhealthy work conditions. Some of the parents are at times forced to send their children to work under conditions of risk due to acute poverty and starvation.

As the problem of child labour is directly connected with the problem of promoting economic and social well-being of the families belonging to lower income strata, its resolution will depend to a large extent on the ability of the Government and society to promote economic and social development of this section of the population, besides providing educational facilities within the reach of all children. An effective enforcement of the existing social legislations protecting the interests of young population, provision of necessary supportive services such as mid-day meals, free supply of text books and uniforms, scholarships for children belonging to the poor families are some of the measures suggested to combat the menace of child labour.[6] But what is more important is to generate public opinion against child labour and involve voluntary organisations, civic bodies and educational institutions in developing effective programmes in this area.

In a welfare state and in a programme, centred round the child as the builder of the society, the persistence of child labour means the sacrifice of the future to the present and the denial of every form of justice to the child concerned.

Children Without Childhood

Poverty and the stranglehold of traditions continue to deprive the Indian child of the opportunities for reasonably healthy physical growth, mental development and protected childhood. Once the economic foundations of the family, the haven of the child, are seriously shaken, the future of the child is doomed. The general atmosphere of neglect and deprivations forces children out of their families into urban areas. Here with niether families nor friends, they manage to by survive seeking work at the tender age of 8-14 years.

They either swell the ranks of sweated labour employed by petty shopkeepers, craftsmen or eating houses, or are forced to join gangs engaged in antisocial and criminal activities. Many of them, however, become vagrants and are condemned, under the provisions of the 'Children's Act', to spend barren years in soulless institutions or 'homes' in the company of contanimating individuals.

There are no reliable statistics of such homeless, destitute children. The Working Group on Policy and Programmes for Destitute Children, set up by the Planning Commission at the time of formulation of the Fourth Plan, determined their number at 0·5 per cent of the total child population. On the basis of this rough estimate, it can be said that there are somewhere between 1·05 million and 1·15 million destitute children in the country. But social workers and others in the field feel that the figure should be much higher and anywhere between 1 per cent and 5 per cent.[7]

There is also no reliable data about the number of orphanages in the country, their conditions, status of services and facilities etc. The Central Social Welfare Board, which aids some 270 orphanages and 40 foundling homes, has made an analysis based on a limited study of 131 institutions which reveals unscientific and qualitatively poor nature of services offered by these institutions to institutionalised children. Institutional form of treatment has the basic limitation of being artificial and unnatural, divorced from the social milieu in which it operates. Farther it goes from social and family norms, worse are the effects on the child. Entire institutional culture with hardly any emotional investments and with its in-built constraints impose severe limitations on the child's growth and development.

Modern trends in social welfare lay increasing emphasis on the need to rehabilitate destitute and abandoned children within a family framework and stress legal adoption as the

ideal for every socially handicapped child. But we have not as yet been able to devise an adoption code that would give every child born on this soil, irrespective of caste or creed, the right of a name and a permanent place outside the institutional pale. The Adoption of children Bill, first introduced in Parliament in 1955 and again in 1972 is still lying in cold storage. The passage of the Bill has run into difficulties due to resistance it has encountered from certain communities.

In the absence of a general law on adoption (except among the Hindus) unscrupulous operators are taking advantage of legal sanctions under the Guardians and Wards Act of 1890. They are helping foreigners take away Indian children, charging fancy fees for getting the cases processed and even buying or 'securing' children from hospitals and smaller orphanages. Meanwhile, the Government has been promoting foster care services but these are in an experimental stage and very limited in operation.

The handicapped child

The handicapped group includes children who suffer from some kind of disability which limits their normal functioning. In recent years, there has been a growing realisation that the handicapped child has a personality of his own, a zest for life and a desire to be a useful member of the society. Handicapped children are classified under the following categories:

(i) Sensorily limited, i.e., blind, deaf-mute etc.

(ii) Orthopaedically handicapped.

(iii) Cerebrally handicapped, i.e., those suffering from brain injury.

(iv) Mentally retarded, i.e., those with low I.Q.

(v) Emotionally distributed, i.e., those suffering from psychotic or neurotic disorders.

No dependable data is available about the size of the handicapped population, especially handicapped children.

India does not have a system of registering and enumerating handicapped children. Handicapped persons were last enumerated in 1931 during census operations. Since then for a number of cogent reasons the Registrar General of Census has discontinued enumerating handicapped persons. Despite these limitations, certain global estimates are widely accepted. According to these, the country has over 3 million handicapped children. There are about 0.5 million blind, 0.2 million deaf, 0.5 million orthopaedically handicapped and nearly 2 million mentally retarded children. The Ganga Saran Sinha Committee, however, considered these figures very conservative and put the number of handicapped children somewhere around 9 per cent of the total child population.[8] On this basis nearly 25 million children in the country should be suffering from one disability or the other.

The services and facilities available for treating, training and rehabilitating handicapped children are highly disproportionate to the size and magnitude of the problem. The country has nearly 200 institutions and associations for the blind which cater to the needs of only 2 per cent of blind children. About 70 schools in the country impart education and training to only 2 per cent of deaf children. For orthopaedically handicapped children there are only about two dozen organisations providing educational and training services to severely crippled children. Similarly, 81 specialised institutions available for treating and caring for mentally retarded children are wholly inadequate. Nor is the supply of trained personnel for manning these institutions commensurate with the need.[9]

Legislative Support and Protection to Child

Legislation for the child had beginnings in the Indian Constitution which provides that,

> "Children and youth should be protected against exploitation and moral and material abandonment" [Directive 30 (F)]. and

"No child below the age of 14 years shall be employed to work in any factory or mine or engaged in any other hazardous employment" (Article 25).

These Constitutional provisions were followed by legislations for children only in some states (Appendix C). Eighteen states are without the requisite acts or minimum legislative measures for the care and protection of the child. It is estimated that, in various States and Union Territories in India there are about 10,000 young offenders below 16 years of age confined to prisons, along with adult offenders.[10] A large majority of delinquents is not spared the formal processing through the hands of the police, the probation officer, the lock-up, and the court. Institutional services under the Children Acts such as Remand Homes, Observation Homes, Special Schools, Certified Schools are still at a developing stage and unless special care is taken to lay down minimum standards, children are not likely to benefit more in these institutions for lack of opportunities for healthy development.

The Adoption of Children Bill, as discussed earlier, is still pending, thus impeding the welfare of millions of destitute children. Child labour and child exploitation for various other purposes is still rampant and well tolerated in spite of the Article 25 and the Direction 30 (F) of the Indian Constitution and several legislative measures enacted to control the menace. It is because these legislations have not been backed by effective enforcement and vigilance machinery,

Child Welfare: Programmes and Services

In the long history of child welfare services in India, voluntary organisations have played a pioneering role. Long before the initiation of development plans in India voluntary organisations were engaged in various programmas and services in the field of child welfare. At the beginning of the First Five Year Plan, there were 558 voluntary organizations rendering welfare services for children.[11] Some of the earliest efforts go back to

the mid-twenties. Significant contributions were made by such organisations as the Indian Council for Child Welfare, the Indian Red Cross Society, the All India Women's Conference and others.

After Independence, the State assumed greater responsibility towards the welfare of children. Governmental concern for the promotion of services for the growth and development of children is evident from a number of expert bodies that have been appointed from time to time. Some of the important ones are : the Health Survey and Planning Committee (1959); the Child Care Committee (1960); the Ganga Saran Sinha Committee (1968) and the Study Group on Pre-school Child (1972). These Committees examined the problems of children in depth and suggested long-term measures and experimental projects for evolving comprehensive services for children.

The *First Plan* (1951-56) observed that "considering the number involved, the needs of children sdould receive much greater consideration then is commonly given to them." The major responsibility for developing child welfare services, however, was placed on voluntary organisations. The need to strengthen the numerous voluntary organisations was recognised and for this purpose a separate board with adequate administrative authority was proposed to be set-up. The Plan further suggested setting up of child guidance clinics, creches, children's centres and services for Juvenile delinquents and handicapped children.

The Central Social Welfare Board was set up in 1953 and initiated 'Welfare Extension Projects' for rendering welfare services to women and children in rural areas. The programme consisted of maternity and child care services, educational and recreational activities for children, adult education and craft training for women.

The *Second Plan* (1956-61) recognised that due to financial limitations, the growth of child welfare services would have

to be a slow process. The role of the Government was viewed as supplementary in nature and that of voluntary organisations primary with some financial assistance from the Government. The Government, however, showed great concern about the problems of Juvenile delinquency and handicapped children. Expansion of institutional programmes and creation of additional facilities such as model schools for blind and deaf children, provision of scholarships to handicapped children and training of teachers for the physically and mentally handicapped children were envisaged.

The Central Social Welfare Board was given the responsibility for promoting voluntary effort in the field of women and child welfare through its grants-in-aid programme. Realising that the Ministry of Community Development was also operating a programme for rural women and children in community development blocks and thus duplicating efforts, the CSWB and the Ministry of Community Development agreed in 1957 to set up Welfare Extension Projects in a coordinated manner. While the programme-content and emphasis remained unchanged, the organisational structure was strengthened and project coverage increased.

The *Third Five Year Plan* (1961-66) re-emphasised the importance of child welfare programmes and stressed that welfare services should be community and family oriented. The concept of organising integrated services for the growth of children was enunciated in the plan and the proposal to take up in each state and Union Territory at least one pilot project in child welfare was made. In order to strengthen the system of pre-school education, a scheme for training of balsevikas was recommended. The problems of juvenile delinquents and beggars received special attention.

The coordinated Welfare Extension Projects of the CSWB were evaluated during this period. The evaluation study strongly supported the idea of recasting the scheme to make

it a composite programme of family and child welfare in which the family could be looked upon as the unit of development. The Family and Child Welfare projects (FCWP) were started in 1967 by converting the Welfare Extension Projects to the new model.

During the third plan, a scheme known as the Integrated Child Care Services Demonstration Projects was started in the country on an experiemental basis. The main activities under the scheme were the provision of integrated services to children in villages, especially to pre-school children; and the provision of basic training to women in home craft, mother craft, health education, nutrition and child care. Eighteen such projects were started in 1967 but the scheme was concluded even before it could strike any roots in the soil. These projects, like the welfare Extension Projects were also converted into the FCW Projects.

The *Fourth Five Year Plan* (1969-74) stressed the importance of organising institutional and non-institutional services for destitute children and allocated special funds for this purpose. The CSWB sponsored 3 foster care service projects, two in Bombay and one in Madras, through which attempts were made to settle destitute or orphan children within a family framework. The Delhi Administration and Punjab Government also launched foster care services. The pattern in all the programmes is that a sum of Rs. 50 is paid to a family to take care of the child and supervising liaison is kept by social workers to safeguard the child's interests of the child.

The Fourth plan identified some weeknesses in the field of welfare planning, i.e. the absence of research and monitoring services, lack of statistical data, deficiencies in management and supervision at the field level and absence of intersectoral coordination. During this period, the CSWB sanctioned grants-in-aid to about 3000 voluntary organisations amounting to a total of Rs. 191 lakhs. The Board started 163 new FCW

Projects bringing the total number of projects to 281. The Board also extended grants-in-aid to voluntary organisations for organising 926 holiday camps for children belonging to low income group families [12]

Besides the three National Institutes for the blind at Dehradun, the deaf at Hyderabad, and the mentally retarded at Delhi, one more Institute for the orthopaedically handicapped was set up at Calcutta. About 7500 scholarships were awarded to the physically handicapped children and youth to enable them prosecute their studies. For the placement of handicapped persons, 9 employment exchanges were set up.[13]

With a view to contributing to the improvement of the social environment in metropolitan towns, the Department of Social Welfare prepared a scheme of *Integrated Services for Children and Youth in Urban Areas* with focus on those residing in urban slums. The scheme envisages the provision of sanitation facilities, primary education, health services, adequate nutrition, recreation, vocational preparation, etc. to children and youth in urban areas in the age group of 0-19. Twelve cities, namely, Bombay, Baroda, Lucknow, Delhi, Madras, Howrah, Indore, Jaipur, Hyderabad, Patna, Trivendrum, and Amritsar have been selected for this scheme and the Centre for Research and Training in Municipal Administration (IIPA), New Delhi, is preparing draft proposals in respect of these cities.[14]

Child Welfare in the Fifth Plan

The Fifth Plan approach aims at a proper integration of welfare and developmental services. A major thrust will be on the expansion of preventive and developmental programmes of child welfare. The Plan envisages the programming of welfare services taking the family as a unit of development and according high priority to child welfare. To ensure healthy growth and development of children, especially those in the age-group 0-6, a scheme known as the Integrated

Child Development Services (ICDS) programme, with emphasis on supplementary nutrition, immunisation, health check-up, referral services, informal education and nutrition education will be launched in the Fifth Plan on a fairly large scale. The programme would be directed at the pre-school children, pregnant women and nursing mothers, particularly those from the weaker sections of society. These efforts are proposed to be further supplemented by the Minimum Needs Programme. as envisional in the plan document for catering to the needs of families of vulnerable groups.

A much-awaited *National Policy for Children Resolution* was adopted by the Government of India in August 1974 (the resolution can be seen in Appendix : 'B'). The Resolution spells out the various measures to be adopted and priority to be assigned to children's programmes with a focus on certain defined areas. The Resolution, *inter alia*, provides for the constitution of a National Children's Board under the Chairmanship of the Prime Minister. This indeed marks a watershed in the child welfare movement in India.

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13. *Ibid*, p. 273.
14. Ministry of Social Welfare, Government of India, *Report*— 1972-73, p. 23.

TABLE 36

Reported Child Labour—India 1961 and 1971

(figures in millions)

1961				1971			
Child Population	Reported Child Labour			Child Population	Reported Child Labour		
(0-14 yrs)	Males	Females	Total	(0-14 yrs)	Males	Females	Total
180	8.7	5.8	14.5	228	7.9	2.8	10.7

Source: Census Reports 1961 and 1971, Office of the Registrar General, Government of India.

TABLE 37

Total Workers all Age-groups and Child Workers (0–14), India, 1971 (Activity-wise)

(population in thousands)

	Total All Age Groups		Child Workers	
	Males	Females	Males	Females
1. Cultivators	68,910	9,266	3,125	746
2. Agricultural labourers	31,695	15.794	3,004	1,582
3. Forestry and Plantations	3,514	783	744	142
4. Mining and Quarry	799	124	14	9
5. Manufacturing industries	14,872	2,196	440	214
6. Construction	2,012	204	42	17
7. Trade and Commerce	9,482	556	198	14
8. Transport	4,255	146	36	6
9. Others	13,536	2,229	282	123
Total Workers	1,49,075	31,298	7,885	2,853

Source: Census Report 1971, Office of the Registrar General of Census, Government of India.

TABLE 38

Rural and Urban Workers and Non-Workers Classified by Sex, Age-group (0–14)—India, 1971

(figures in thousands)

	Total workers			Total non-workers			Proportion of total workers to total population of children in India
	Total	Males	Females	Total	Males	Females	
Rural	9954	7278	2686	177716	89555	88161	5.31
Urban	775	607	168	41800	21430	20370	1.82
Total	10739	7885	2854	219516	110985	108531	4.66

Source: Census of India 1971, Series I, Paper 3 of 1972, Registrar General and Census Commissioner, India.

CHAPTER : VI

FUTURE PERSPECTIVE

"We are guilty of many errors and many faults but our worst crime is abandoning the childen, neglecting the fountain of life. Many of the things we need can wait. The child cannot. Right now is the time his bones are being formed, his blood is being made and his senses are being developed. To him we cannot ansewer 'Tomorrow'. His name is 'Today'."

Gabriela Mistral
Nobel Prize winning poet
from Chile.

The Child in Second India

The major programmes directed to children, which have been discussed earlier, and experience of implementing for over two decades the child welfare programme in the country have now culminated in the inter-sectoral package deal covering 10 million women and children. But it is only a starting point. The task ahead is much more complex and difficult as we shall have to live with the problem of rapid population growth for the rest of the century and have to serve the children of India over the turn of the century i.e. Second India which is likely to consist of almost one billion people who will seek survial and fulfilment as human beings.

According to the population projections, adopted by the Planning Commission, India's population has increased from 547 million in 1971 to 581 million in 1974, and is likely to be 705 million in 1986. It is expected that by the turn of the

century the declining birth-rates will slowly lead to a fall in the proportion of young population to total population. Charts 19 & 20 give details of the expected population in different age groups in the rural and urban population relevant to the Second India, under medium-2 assumption. It is interesting to note that the ratio of dependency is likely to fall from 8989 in 1971 to 6835 in 2001 in rural areas and from 8754 to 6496 in urban areas[1] (as illustrated in Chart: 21).

Assuming this pattern of population growth in India, some consequences in terms of minimum additional facilities needed by children can be projected :

1. The additional India which will be born between now and the year 20001 will have to be schooled. Taking into consideration the population growth under the assumptions stated by Raghavachari, according to medium-2 projections, there will be 437.8 million boys and 411.58 million girls in rural India and 165.31 million boys and 159.43 million girls in urban India who will need to be enrolled in elementary schools. A simple calculation shows that we will need to put up one new school for 250 pupils, some where in the country, every two hours just to school the increase in population, one or two new schools fully equipped with men and material, in each district every week. If we wish to fulfill the Constitutional obligation, reiterated in the National Policy Resolution for Children, to provide free and compulsory education upto the age of 14 for all, then we need to build some half a million schools of this size during the next 25 years. In other words, school space will have to be provided for three times as many pupils during the next 25 years as we have been able to provide during the last 25 years.

Even so, the tragic part of this problem is that although, since Independence until now, the population of pupils in this age group has risen from 34 per cent to 69 per cent, the total number of non-pupils has almost remained the same, at around

40 million. It has been worked out that unless we manage to have an enrolment of more than 85 per cent in the year 2001 it will still be 4o million at the end of the century[2].

2. In the sphere of health services, it has been estimated that India's population by the turn of the century is likely to have 220 million more young couples in the reproductive age group. A comparatively higher percentage of population is likely to survive to old age. It has been estimated that if the present trends in fertility and mortality continue, India will need more than double the existing physical health facilities, and medical and para-medical personnel, even to keep up the current norms and standards. On the basis of at least one PHC for each block, an additional number of 4000 new PHCs would be required by the year 2001.

Similarly, the number of buildings and auxiliary staff at the sub-centre will have to be increased considerably in order to equip the estimated number of 94,538 sub-centres by that period. The requirement of doctors will go up to 2,70,100; of dentists 31,513; nurses 1,89,071; and sanitary inspectors 94,538, in order to maintain the existing level and standard of health services. An equal number of ANMs will be required if the existing level of facilities is to be maintained.[3]

3. On the nutrition front, in order to meet the demands of the population in the year 2001, even at the current level of per capita availability, our food production will have to increase to obout 180 million tonnes. But this would help only in avoiding further deterioration in our nutritional standards. Even on the basis of the least-cost balanced diets proposed by the ICMR we will have to boost our milk production by 200 per cent and production of oil, meet, fish and poultry by 400 per cent in order to meet the full nutritional demands of our population, espicially the young population by 2001.[4] The main road-block in the way of achievement of balanced diets by all the sections in population is the strong likelihood that

the availability of milk, fish, poultry, fruits and vegatables etc. would lag by a large margin behind the growing demand for these items by the better-off groups of people.

It is obvious that expansion of nutrition programmes beyond a point would be limited by the availabitity of food resources and that this point would come early enough. In the decade ahead, it has been pointed out that India's quest for more nutrition to her poor and young population will depend as much on nutritional break-throughs as on the technological break-throughs in agriculture and food production.[5]

Some Policy Implications

What is happening in India, in terms of its existing and projected *modus vivendi,* is typical of what is taking place in many developing societies in our time. It is imperative that every effort will have to be made to create institutions, situations and educational systems that will permit and promote growth, integration, confidence and mutually creative exchanges between and interactions with, the environment of the child. Governments, voluntary organisations, schools, universities, religious institutions and families will have to become much more aware of the changing needs of young childern and the necessity to reconstruct the social system in such a way as to enhance creativity and optimal growth of the child in times to come.

In India 40 per cent population is beleived to be below the stark poverty line and large sections of population just a little above it (Chart:25). Even more than the absolute levels of poverty prevailing in the country, the matter of greater concern is the large disparities of income having its manifestations in conspicuous consumption of the few to the deprivation of the many. The context described above suggests the need for a hard-headed policy towards nutrition in India. Such a policy needs to be pragmatic enough to focus its benefits on the more vulnerable groups among the

poor and capable and discriminating enough to reach the worst-affected areas and populations.

It has been held that the earliest possible completion of the unfinished public health revolution in the country is bound to yield results more substantial than direct programmes of nutritional intervention for expectant and nursing mothers, infants and pre-school children.[6] Experience has shown that the malaria eradication programmes of the 1950s have had far more positive effect on conserving and promoting nutrition among people particularly the young, than the sum of all supplementary nutrition programmes undertaken so far. Of necessity, a nutrition programme, with an eye on cost-benefit ratios, will have to concentrate rather more on prevention of wastage and leakage of nutrition than on any positive delivery system directed to target groups for the simple reason that the former enjoys much greater chances of benefitting the lower social income strata for which they are intended.

It has also been established that malnutrition and diseases caused or suported by malnutrition account for the large incidence of child wastage. Such a mortality incidence explains a large measure of non-acceptance of family planning. Ensuring child survival is a crucial condition for achieving the goal of a small and healthy family. Once the parents have confidence that their children will survive, they will have fewer children. A comprehensive nutrition programme, therefore, should not only aim at improvement of diet but also at improvement of environmental sanitation, control of infections, provision of protected water supply, nutrition and health education and family planning. An integrated programme, including such mutually reinforcing components, will be the most rewarding strategy in the Indian context.

Such a strategy must simultaneously encompass programmes and services related to environmental sanitation in villages and towns, disposal of sewage and wastes and the

universal immunisation programme against tetanus for expectant mothers and against smallpox, enteric diseases, diptheria and tuberculosis for infants and very young children. The priority areas in maternal and child health services will have to be management of pregnancy and child birth, child heaith and family planning. Basic services needed are antenatal, natal and postnatal care, health supervision of infants and children etc. Health and nutrition education forms an essential part of this package. The prime emphasis must still lie on primary education and functional literacy without which any message on health, nutrition or family planning is extremely difficult to put across.

Two important lessons from the experience of implementing for over two decades the programmes of child care and development in the country have surfaced. One is that none of the existing health, nutrition. education and other social welfare measures is nearly as effective as the situation demands, and the other, is that the fragmentary and compartmentalised approach is the reason for this lag. What safeguards mnst be provided to meet the existing and projected needs of our young population are reflected in the package of services envisioned for the ICDS programme. There is, undoubtedly, need to coordinate the activities of various departments and agencies concerned with children's welfare, official and non-official, so that a true appraisal of the work being done—or yet undone—is possible. This is imperative for meaningful planning for the decade ahead. The Government's decision to set up a National Children's Board to draw up a national policy for children has not come too soon.

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Chart : 19

Age Structure, India - 2001 A-D
(Rural/Urban and Sex - wise)
Assumption : Medium - 2

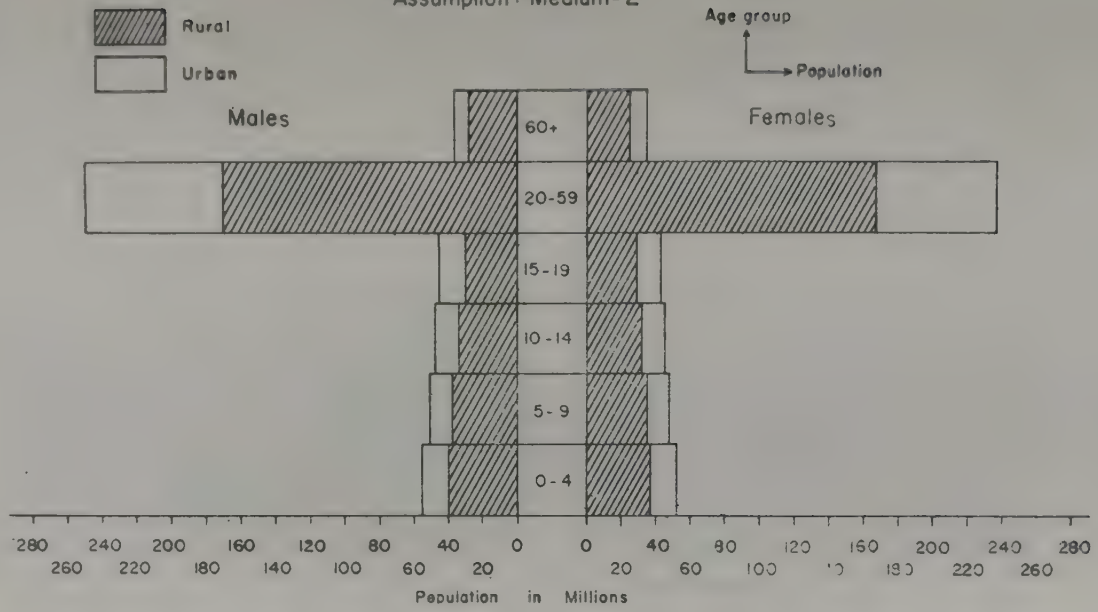


Chart : 20

Age Structure
1971 and 2001

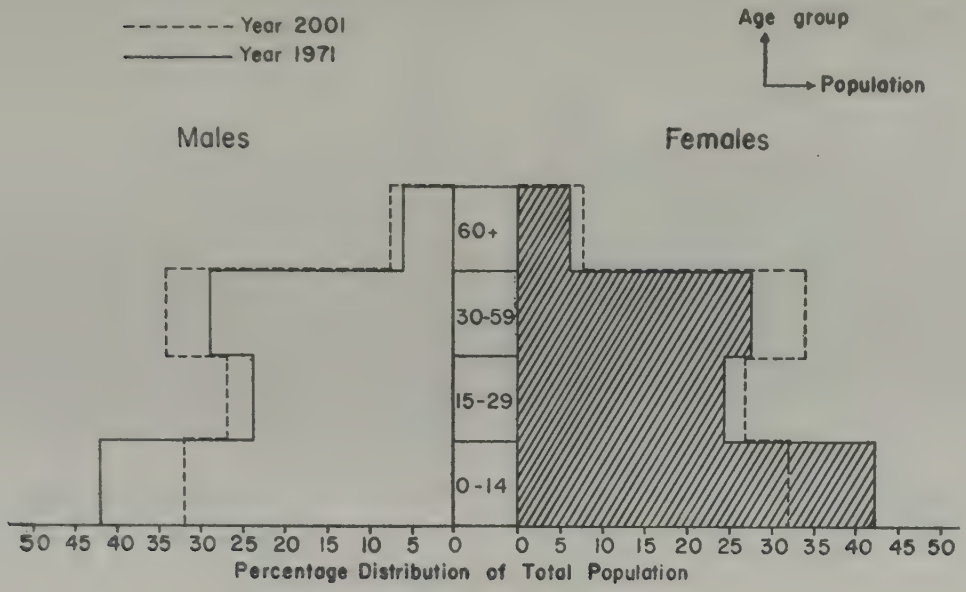
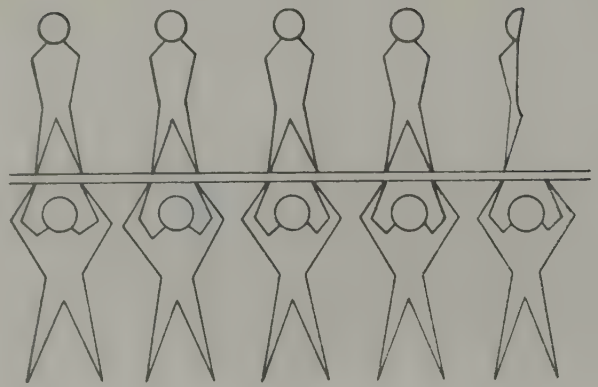


Chart : 21

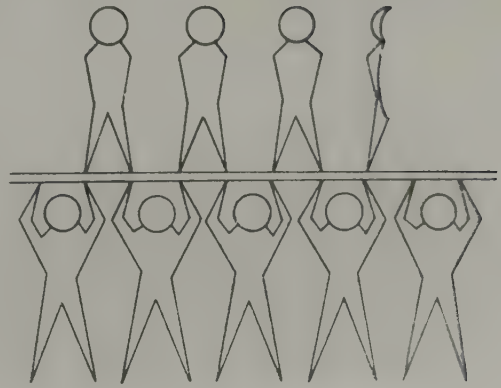
Dependency Ratio
1971 and 2001

Year 1971



Dependency Ratio- ·8754

Year 2001



Dependency Ratio-·649[illegible]

Chart : 22

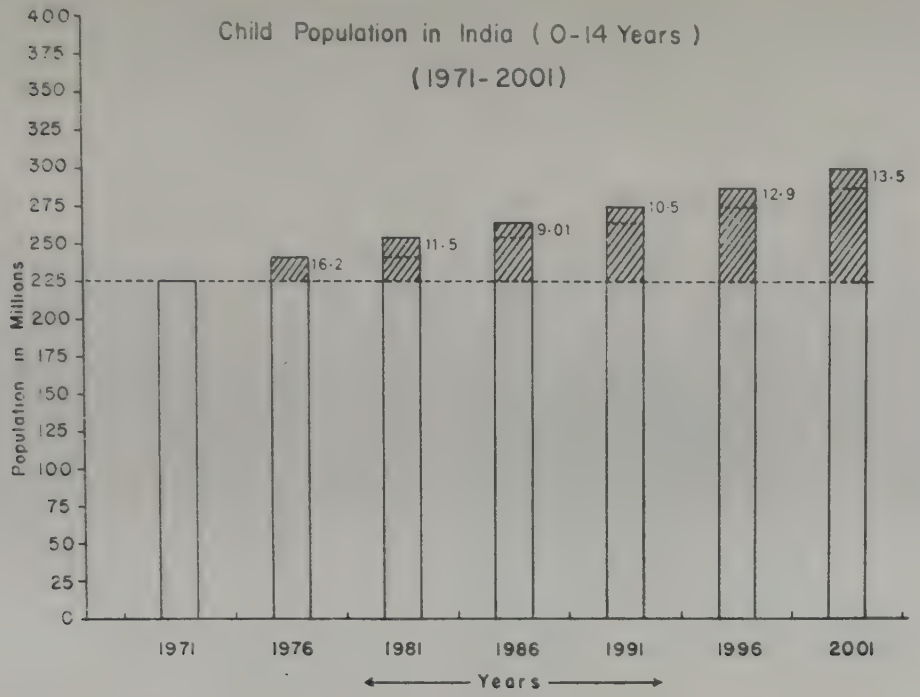

Child Population in India (0-14 Years)
(1971-2001)
Population in Millions
400
375
350
325
300
275
250
225
200
175
150
125
100
75
50
25
0
16·2
11·5
9·01
10·5
12·9
13·5
1971
1976
1981
1986
1991
1996
2001
Years

Chart : 23

Distribution of Children all India
1961 - 81

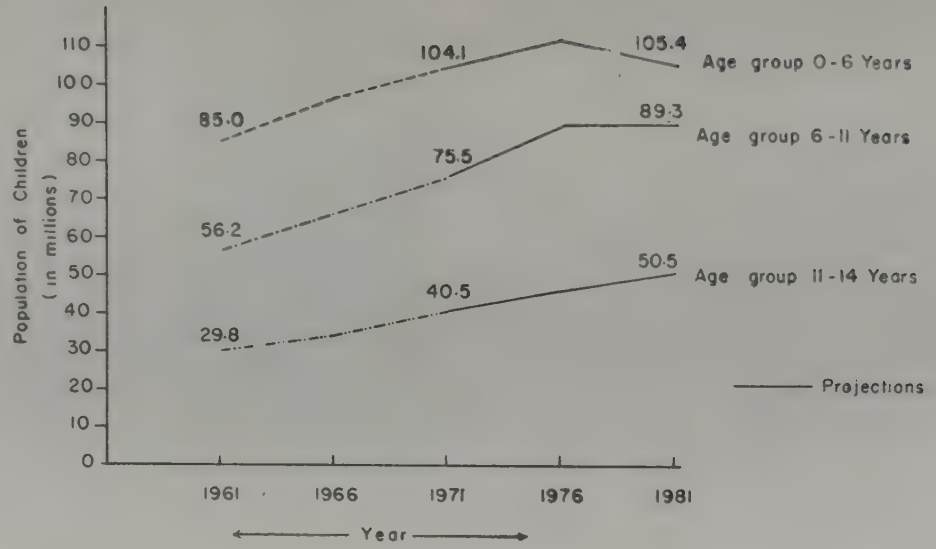


Chart : 24

Child Population of India (0-14) by Age and Sex
1971 - 2001

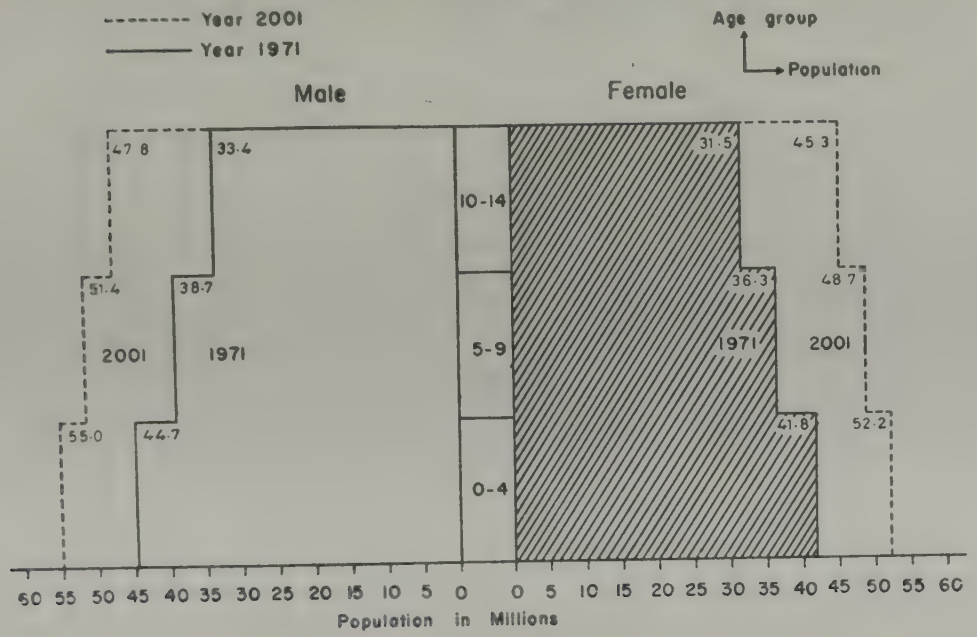
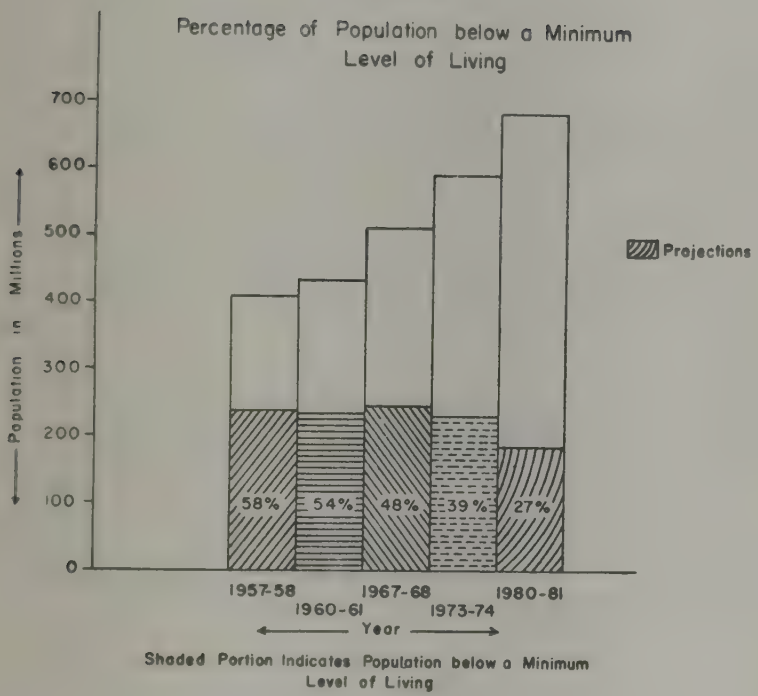


Chart 25



Shaded Portion Indicates Population below a Minimum Level of Living

TABLE 39

Population Projection for Different Ages: Rural/Urban and Sex-wise 2001 A.D.
Assumption: Medium–2

(figures in thousands)

	Males			Females			Total		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
0–4	39941 (11.78)	15081 (10.32)	55022 (11.38)	37663 (11.48)	14590 (11.04)	52253 (11.36)	77604 (11.63)	29671 (10.66)	107275 (11.34)
5–9	37360 (11.02)	14107 (9.65)	51467 (10.60)	35113 (10.71)	13601 (10.29)	48714 (10.59)	72473 (10.86)	27708 (9.96)	100181 (10.64)
10–14	34729 (10.23)	13114 (8.97)	47843 (9.78)	32670 (9.96)	12655 (9.58)	45325 (9.85)	67399 (10.10)	25769 (9.76)	93168 (9.86)
15–19	30166 (8.90)	15630 (10.69)	45796 (9.48)	29772 (9.08)	13710 (10.38)	43482 (9.45)	59938 (8.99)	29340 (10.54)	89278 (9.44)
20–59	169486 (49.98)	79051 (54.07)	248537 (51.21)	166819 (50.87)	68476 (51.83)	235295 (51.14)	336305 (50.42)	147527 (53.01)	483832 (51.18)
60+	27444 (8.09)	9211 (6.30)	36655 (7.55)	25905 (7.90)	9090 (6.88)	34995 (7.61)	53349 (8.00)	18301 (6.57)	71650 (7.58)
All Ages	339126 (100.00)	146194 (100.00)	485320 (100.00)	327942 (100.00)	132122 (100.00)	460064 (100.00)	667068 (100.00)	278316 (100.00)	945384 (100.00)

Source: Social Service in Second India, Council for Social Development, 1974, Table : 4.

TABLE 40

Percentage Distribution of Total Population of India by Broad Age Groups 1971 and 2001

Sex	Males		Females	
Age Group	1971	2001	1971	2001
0–14	41.9	31.8	42.2	31.8
15–29	23.5	26.69	24.3	26.7
30–59	28.7	34.0	27.5	33.85
60+	5.9	7.51	6.00	7.60

Source: 1971: Census Figures.
2001: Raghavchari's Paper on Population Projections, Medium-2.

TABLE 41

Projected Population of India (0–14) by Age and Sex 1971—2001 According to Medium-2, Fertility Assumption

(population in thousands)

Age Group	1971			1976			1981		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
0–4	44745	41846	86591	44520	42551	87071	46338	44376	90714
5–9	38763	36384	75147	42427	39419	81846	42557	40487	83044
10–14	33426	31492	64918	38147	35871	74018	41858	38918	80776
	1986			1991			1996		
0–4	48183	46003	94186	49639	47238	96877	52825	50143	102968
5–9	44596	42526	87122	46632	44347	90979	48239	45741	93980
10–14	42068	40175	82243	44154	42079	86233	46217	43917	90134
	2001								
0–4	55022	52253	107275						
5–9	51467	48714	100181						
10–14	47843	45325	93168						

Source : Population in India's Development 1947–2000, pp. 440-41.

TABLE 42

Projected Population (1971–2001), Under Medium-2 Fertility Assumption

(population in thousands)

Year	Total Population			0-14 group			Differential	%Variation
	Males	Females	Total	Males	Females	Total		
1971	2,83,409	2,63,544	5,46,953	1,16,934	1,09,722	2,26,656	—	—
1976	3,13,456	2,92,101	6,05,557	1,25,094	1,17,841	2,42,935	+16,279	+7.18
1981	3,45,316	3,22,911	6,68,225	1,30,753	1,23,781	2,54,534	+11,599	+4.77
1986	3,78,604	3,55,414	7,34,018	1,34,847	1,28,704	2,63,551	+ 9,017	+3.54
1991	4,12,616	3,88,575	8,01,191	1,40,425	1,33,664	2,74,089	+10,538	+3.99
1996	4,48,678	4,23,880	8,72,558	1,47,281	1,39,801	2,87,082	+12,993	+4.74
2001	4,85,320	4,60,064	9,45,384	1,54,332	1,46,292	3,00,624	+13,542	+4.71

Source: Adapted from Population Projections, 1976-2001 by S. Raghavachari in Population in India's Development 1947–2000, pp. 439-40.

TABLE 43

Distribution of Children (0–14) All India 1961–1981

(figures in thousands)

Age groups in years	1961	%	1966	%	1971	%	1976	%	1981	%
0–6	85020	49.7	95650	48.9	104110	47.3	110630	45.0	105460	43.0
6–11	56240	32.9	65780	33.6	75520	34.3	89380	36.4	89380	36.4
11–14	29840	17.4	34130	17.5	40510	18.4	45720	18.6	50550	20.6
Total	171100	100.0	195560	100.0	220140	100.0	245730	100.0	245900	100.0

Source: Computed from basic cyclostyled sheets of the Registrar General's office, Government of India.

TABLE 44

Comparative Study of Sex Ratio and Dependency Ratio for 1971 and 2001, Rural/Urban

	Year	Rural	Urban	Total
Sex Ratio	1971	949	858	930
	2001	967	904	948
Dependency Ratio	1971	8989	7861	8754
	2001	6835	5736	6494

Note: The above figures are computed from the population projections under Assumption Medium-2.

Source: Social Services in Second India, Council for Social Development, New Delhi, Nov. 1974, Table : 6.

TABLE 45

Percentage of Population below a Minimum Level of Living

Year	Total Population (in millions)	Population below minimum level (in millions)	Percentage
1957-58	410	238	58
1960-61	435	235	54
1967-68	514	247	48
1973-74	594	232	39
		(226)	(38)
1980-81	688	176	27
		(145)	(21)

Note:— For computing percentage of population below a minimum level of living a standard of private consumption expenditure of Rs. 240 (in 1960-61) per capita per year, has been adopted as a bare minimum. Figures in parentheses indicate lower bounds if some specific measures aimed at improving the economic status of the weaker sections of the society succeeded.

Source: *The Poor, the weak and the Fourth Plan*, a cyclostyled paper by B. S. Minhas.

APPENDIX : A

DECLARATION OF GENEVA

At its plenary session of 26th September 1924, the Fifth Assembly of the League of Nations unanimously adopted the following resolution : "The Assembly endorses the Declaration of Rights of the Child, commonly known as the Declaration of Geneva, and invites the States Members of the League to be guided by its principles in the work of child welfare".

By the present Declaration of the Rights of the Child, commonly known as the "Declaration of Geneva", men and women of all nations, recognising that mankind owes to the Child the best that it has to give, declare and accept it as their duty that, beyond and above all considerations of race, nationality or creed :

1. *The child* must be given the means requisite for its normal development, bothm aterially and spiritually.
2. *The child* that is hungry must be fed ; the child that is sick must be nursed ; the child that is backward must be helped ; the delinquent child must be reclaimed ; and the orphan and the waif must be sheltered and succoured.
3. *The child* must be the first to receive relief in times of distress.
4. *The child* must be put in a position to earn a livelihood, and must be protected against every form of exploitation.
5. *The child* must be brought up in the consciousness that its talents must be devoted to the service of its fellow-men.

Declaration of the Rights of the Child

In 1923 the Save the Children International Union, which was later to become the International Union for Child Welfare (I.U.C.W.), promulgated the first Declaration of the Rights of the Child, also called "Declaration of Geneva", which set forth in five points the rights of the child and the duties of humanity towards him. In 1924 this declaration was adopted by the League of Nations which ten years later, confirmed its adhesion to this text, thereby consecrating it as the "World Children's Charter".

In the aftermath of the Second World War, the United Nations Organisation was asked to adopt the Declaration of Geneva, with a few modifications. In 1948, the General Council of the International Union for Child Welfare accepted a revised text counting seven points and including an additional clause on non-discrimination based on race, nationality and religious faith—concept previously contained in the preamble—and another implying the concept that the child should be helped with due respect for the integrity of his family. Some further specifications were also added, mainly relating to provisions for social welfare and security.

In 1950, the United Nations Economic and Social Council submitted a new project, but it was not until 1959, a month after the adoption of the Declaration of Human Rights by the United Nations General Assembly, that the latter adopted the new ten point Declaration of the Rights of the Child, which incorporates all the principles set out in the Declaration of Geneva. Following is the text of the declaration :

Whereas the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights, and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom.

Whereas the United Nations has, in the Universal Declaration of Human Rights, proclaimed that every one is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Whereas the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.

Whereas the need for such special safeguards has been stated in the Geneva Declaration of the Rights of the Child of 1924, and recognized in the Universal Declaration of Human Rights and in the statutes of specialized agencies and international organizations concerned with the welfare of children.

Whereas mankind owes to the child the best it has to give. Now therefore, The General Assembly Proclaims this Declaration of the Rights of the Child to the end that he may have a happy childhood and enjoy for his own good and for good of society the rights and freedoms herein set forth, and calls upon parents, upon men and women as individuals and upon voluntary organizations, local authorities and national governments to recognize these rights and strive for their observance by legislative and other measures progressively taken in accordance with the following principles :

1. *The child* shall enjoy all the rights set forth in this Declaration. All children, without any exception whatsoever, shall be entitled to these rights, without distinction or discrimination on account of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, whether of himself or of his family.

2. *The child* shall enjoy special protection and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually

and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose the best interests of the child shall be the paramount consideration.

3. *The child* shall be entitled from his birth to a name and a nationality.

4. *The child* shall enjoy the benefits of social security. He shall be entitled to grow and develop in health; to this end special care and protection shall be provided both to him and to his mother, including adequate prenatal and post-natal care. The child shall have the right to adequate nutrition, housing, recreation and medical services.

5. *The child* who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition.

6. *The child*, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and in any case in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother. Society and the public authorities shall have the duty to extend particular care to children without a family and to those without adequate means of support. Payment of state and other assistance toward the maintenance of children of large families is desirable.

7. *The child* is entitled to receive education, which shall be free and compulsory, at least in the elementary stages. He shall be given an education which will promote his general culture, and enable him on a basis of opportunity to development, and his sense of moral and social responsibility, and to become a useful member of society.

The best interests of the child shall be the guiding principle of those responsible for his education and guidance; that responsibility lies in the first place with his parents.

The child shall have full opportunity for play and recreation, which should be directed to the same purposes as education; society and the public authorities shall endeavor to promote the enjoyment of this right.

8. *Tha child* shall in all circumstances be among the first to receive protection and relief.

9. *The child* shall be protected against all forms of neglect, cruelty and exploitation. He shall not be the subject of traffic, in any form

The child shall not be admitted to employment before an appropriate minimum age; he shall in no case be caused or permitted to engage in any occupation or employment which would prejudice his health or education, or interfere with his physical, mental or moral development.

10. *The child* shall be protected from practices which may foster racial, religious and any other form of discrimination. He shall be brought up in spirit of understanding, tolerance, friendship among peoples, peace and universal brotherhood and in full consciousness that his energy and talents should be devoted to the service of his fellow men.

APPENDIX : B

Government of India Department of Social Welfare
New Delhi, the 22nd August, 1974

SUBJECT—National Policy for Children

RESOLUTION

No. 1-14/74-CDD.—The Government of India have had under consideration the question of evolving a national policy for the welfare of children. After due consideration, it has been decided to adopt the policy enunciated below:—

Introduction

1. The nation's children are a supremely important asset. Their nurture and solicitude are our responsibility. Children's programme should find a prominent part in our national plans for the development of human resources, so that our children grow up to become robust citizens, physically fit, mentally alert and morally healthy, endowed with the skills and motivations needed by society. Equal opportunities for development to all children during the period of growth should be our aim, for this would serve our larger purpose of reducing inequality and ensuring social justice.

Goals

2. The needs of children and our duties towards them have been expressed in the Constitution. The resolution on a National Policy on Education, which has been adopted by Parliament, gives direction to State Policy on the educational needs of children. We are also party to the U.N. declaration of the Rights of the Child. The goals set out in these documents can reasonably be achieved by judicious and efficient use of the available national resources. Keeping in view these

goals, the Government of India adopts this Resolution on the National Policy for Children.

Policy and measures

3. It shall be the policy of the State to provide adequate services to children, both before and after birth and through the period of growth, to ensure their full physical, mental and social development. The State shall progressively increase the scope of such services so that, within a reasonable time, all children in the country enjoy optimum conditions for their balanced growth. In particular, the following measures shall be adopted towards the attainment of these objectives :

(i) All children shall be covered by a comprehensive health programme.

(ii) Programmes shall be implemented to provide nutrition services with the object of removing deficiencies in the diet of children.

(iii) Programmes will be undertaken for the general improvement of the health and for the care, nutrition and nutrition education of expectant and nursing mothers.

(iv) The State shall take steps to provide free and compulsory education for all children upto the age of 14 for which a time-bound programme will be drawn up consistent with the availability of resources. Special efforts will be made to reduce the prevailing wastage and stagnation in schools, particularly in the case of girls and children of the weaker sections of society. The programme of informal education for pre-school children from such sections will also be taken up.

(v) Children who are not able to take full advantage of formal school education shall be provided other forms of education suited to their requirements.

(vi) Physical education, games, sports and other types of recreational as well as cultural and scientific activities

shall be promoted in schools, community centres and such other institutions.

(vii) To ensure equality of opportunity special assistance shall be provided to all children belonging to the weaker sections of the society, such as children belonging to the Scheduled Castes and Scheduled Tribes and those belonging to the economically weaker sections, both in urban and rural areas.

(viii) Children who are socially handicapped, who have become delinquent or have been forced to take to begging or are otherwise in distress, shall be provided facilities for education, training and rehabilitation and will be helped to become useful citizens.

(ix) Children shall be protected against neglect, cruelty and exploitation

(x) No child under 14 years shall be permitted to be engaged in any hazardous occupation or be made to undertake heavy work.

(xi) Facilities shall be provided for special treatment, education rehabilitation and care of children who are physically handicapped, emotionally disturbed or mentally retarded.

(xii) Children shall be given priority for protection and relief in times of distress or natural calamity.

(xiii) Special programmes shall be formulated to spot, encourage and assist gifted children, particularly those belonging to the weaker sections of society.

(xiv) Existing laws should be amended so that in all legal disputes, whether between parents or institutions, the interests of children are given paramount consideration.

(xv) In organising services for children, efforts would be directed to strengthen family ties so that full potentialities of growth of children are realised within the

normal family, neighbourhood and community environment.

Priority in programme formulation

4. In formulating programmes in different sectors, priority shall be given to programmes relating to

(a) preventive and promotive aspects of child health;
(b) nutrition for infants and children in the pre-school age along with nutrition for nursing and expectant mothers;
(c) maintenance, education and training of orphan and destitute children;
(d) creches and other facilities for the care of children of working or ailing mothers; and
(e) care, education, training and rehabilitation of handicapped children.

Constitution of National Children's Board

5. During the last two decades we have made significant progress in the provision of services for children on the lines detailed above. There has been considerable expansion in the health, nutrition, education, and welfare services. Rise in the standard of living, wherever it occurred, has indirectly met children's basic needs to some extent. But all this work needs a focus and a forum for planning and review, and proper coordination of the multiplicity of services striving to meet the needs of children. A National Children's Board shall be constituted to provide this focus and to ensure at different levels continuous planning, review and coordination of all the essential services. Similar Boards may also be constituted at the State level.

Role of Voluntary Organisations

6. The Government shall endeavour that adequate resources are provided for child welfare programmes and appropriate schemes are undertaken. At the same time, voluntary organisations engaged in the field of child welfare

will continue to have the opportunity to develop, either on their own or with State assistance, in the field of education, health, recreation and social welfare services. India has a tradition of voluntary action. It shall be the endeavour of the State to encourage and strengthen voluntary action so that State and voluntaty efforts complement each other. The resources of voluntary organisations, trusts, charities and religious and other endowments would have to be tapped to the extent possible for promoting and developing child welfare programmes.

Legislative and Administrative Action

7. To achieve the above aims, the State will provide necessary legislative and administrative support. Facilities for research and training of personnel will be developed to meet the needs of the expanding programmes and to improve the effectiveness of the services.

People's participation

8. The Government of India trust that the policy enunciated in this statement will receive the support and cooperation of all sections of the people and of organisations working for children. The Government of India also calls upon the citizens, State Governments, local bodies, educational institutions and voluntary organisations to play their part in the overall effort to attain these objectives.

P. N. LUTHRA
Secretary to the Government of India.

ORDER

ORDERED that a copy of the resolution be communicated to the Cabinet Secretariat, the Prime Minister's Secretariat, all the Ministries/Departments of the Government of India, the Planning Commission, the State Government and the Governments/Administrations of Union Territories—

ORDERED also that the resolution be published in the Gazette of India for general information.

P. N. LUTHRA
Secretary to the Government of India.

APPENDIX : C

LEGISLATION CONCERING CHILDREN IN INDIA

List of Central Acts Concerning Children

Personal Laws

1. Female Infanticide Prevention Act—1870
2. Indian Majority Act—1875
3. Guardianship and Wards Act—1890
4. Hindu Marriage Act—1955
5. Hindu Inheritance Act—1955
6. Hindu Minority and Guardianship Act—1956
7. Hindu Adoption and Maintenance Act—1956
8. Children Act—1960

Child Health

9. Vaccination Act—1880

Child Employment

10. Factories Act—1881
11. Apprentices Act—1850
12. Children (Pledging of labour) Act—1933
13. Employment of Children Act—1938
14. Motor Vehicle Act—1939
15. Factories Act-1948
16. Plantation Labour Act—1951
17. Mines Act—1952
18. Indian Merchant Shipping Act—1958
19. Motor Transport Workers Act-1961

Child Marriage

20. Child Marriage Restraint Act—1929
21. Hindu Marriage Act—1955

Probation and Reformatory Services

22. Reformatory Schools Act—1897
23. Probation of Offenders Act—1958
24. Suppression of Immoral Traffic Act—1956

Children Homes

25. Women and Children's Institutions (Licensing) Act—1956
26. Orphanages and other Charitable Homes (Supervision and Control) Act—1960

Crimes and Criminal Procedure

27. Indian Penal Code Amendment Act—1949
28. Code of Criminal Procedure Act—1973

List of State Acts Concerning Children

Andhra Pradesh

1. Hyderabad Children Protection Act—F. 1343
2. Hyderabad Court of Wards Act—F. 1350
3. Hyderabad Prevention of Beggary Act—F. 1350
4. Hyderabad Children Act—1951
5. Hyderabad Vaccination Act—1951
6. Hyderabad Shops and Commercial Establishment Act—1951
7. Hyderabad Compulsory Primary Education Act—1952

F = Fazali Era

Assam

1. Assam Court of Wards Act—1879
2. Assam Students and Juvenile Smoking Act—1923
3. Assam Primary Education Act—1926
4. Assam Shops and Commercial Establishments Act—1948
5. Assam Court of Wards (Delegation of Powers) Act—1943
6. Assam Prevention of Beggary Act -1964
7. Assam Children Act—1971.

Bihar

1. Bihar Court of Wards Act—1879
2. Bihar and Orrissa Primary Education Act—1919
3. Bihar Prevention of Beggary Act—1951

4. Bihar Shops and Establishment Act—1954
5. Reformatory Schools (Bihar Amendment) Act –1956
6. Bihar Supervision of Orphanages Act—1957
7. Bihar Children Act—1969

Bombay

1. Bombay Vaccination Act—1877
2. Bombay Court of Wards Act—1905
3. Bombay Borstal Schools Act—1929
4. Bombay Probation of Offenders Act—1938
5. Bombay Shops and Establishment Act—1948
6. Bombay Primary Education Act—1947
7. Bombay Children Act—1948
8. Bombay Prevention of Begging Act—1959

Jammu and Kashmir

1. J. & K. Guardians and Wards Act—BK 1977
2. J. & K. Court of Wards Act—BK 1977
3. J. & K. Majority Act—BK 1977
4. J. & K. Infant Marriage Prevention Act—BK 1985
5. J. & K. Juvenile Smoking Act—BK 1986
6. J. & K. Primary Education Act—BK 1986
7. J. & K. Suppression of Immoral Traffic Act—BK 1991
8. J. & K. Children (Pledging of Labour) Act—BK 2002
9. J. & K. Vaccination Act—BK 2006
10. J. & K. Factories Act—1957
11. J. & K. Children Act—1969

BK = Bikrami Era

Kerala

1. Travancore Court of Wards Act—K 1110
2. Cochin Court of Wards Act—K 1097
3. Cochin Children Act—K 1111
4. Cochin Juvenile Smoking Act—K 1096
5. Travancore Prevention of Begging Act—K 1120
6. Travancore Children Act—K 1120
7. Travancore Borstal Schools Act—K 1120

8. Cochin Vagrancy Act—K 1120
9. Travancore Primary Education Act—K 1121
10. Free Compulsory Education Act—K 1123
11. Travancore Cochin Shops and Establishment Act—K 1125
12. Elementary Education Act—1920

K=Killam Year

Madhya Pradesh

1. Central Provinces Court of Wards Act—1889
2. Madhya Pradesh Borstal Act 1928
3. Madhya Pradesh Children Act—1928
4. Madhya Pradesh Juvenile Smoking Act—1929
5. Bhopal State Protection of Orphans Act—1930
6. Compulsory Primary Education Act—1949
7. Prevention of Children's taking of Intoxicants Act—1950
8. Vindhya Pradesh Primary Education Act—1952
9. Women and Children Institutions Licencing Act—1954
10. M.P. Primary Education Act—1956
11. Madhya Pradesh Children Act—1970

Madras

1. Madras Court of Wards Act—1902
2. Madres Children Act—1920
3. Madras Elementary Education Act—1920
4. Madras Borstal Schools Act—1926
5. Madras Probation of Offenders Act—1937
6. Madras Prevention of Begging Act—1945
7. Madras Shops and Establishment Act 1947

Nysore

1. Mysore Prevention of Juvenile Smoking Act—1911
2. Mysore Borstal Schools Act—1943
3. Mysore Children Act—1943
4. Mysore Prohibition of Beggary Act—1944
5. Mysore Probation of Offenders Act—1943
6. Mysore Shops and Establishment Act—1948
7. Mysore Children Act—1964

Orissa

1. Orissa Court of Wards Act—1947
2. Orissa Basic Education Act—1951
3. Orissa Shops and Commercial Establishments Act—1956

Punjab

1. Punjab Juvenile Smoking Act—1918
2. Punjab Primary Education Act—1919
3. Punjab Primary Education Enforcement Act—1926
4. Punjab Shops and Commercial Establishments Act—1925
5. Punjab Borstal Schools Act—1926
6. Punjab Primary Education Act—1940
7. East Punjab Children Act—1949
8. Punjab Court of Wards (Repeal) Act—1956
9. Punjab Court of Wards (Validation of Exercise of Powers) Act—1957
10. Punjab Vaccination Act-1953

Rajasthan

1. Rajasthan Prevention of Juvenile Smoking Act—1950
2. Rajasthan Court of Wards Act—1951
3. Rajasthan Vaccination Act—1957
4. Rajasthan Shops and Commercial Establishments Act—1958
5. Rajasthan Children Act—1970

Saurashtra

1. Saurashtra Children Act—1954

Uttar Pradesh

1. U. P. Court of Wards Act—1912
2. U. P. Primary Education Act—1919
3. U. P. S. I. T. Act—1933
4. U. P. Borstal Act—1938
5. U. P. Shops and Commercial Estabilishment Act—1947
6. U. P. Children Act—1951
7. U. P. Women's and Children's Institutions (Control) Act—1957

West Bengal

1. Bengal Court of Wards Act—1879
2. Bengal Vaccination Act—1880
3. Bengal Juvenile Smoking Act—1919
4. Bengal Primary Education Act—1917
5. Bengal Children Act—1922
6. Bengal Borstal Schools Act—1928
7. Bengal Rural Primary Education Act—1930
8. Bengal Shops and Establishment Act—1940
9. Bengal Court of Wards (Amendment) Act—1941
10. Bengal Vagrancy Act—1943
11. Bengal Orphanages Act—1944
12. West Bengal Probation of Offenders Act—1954
13. West Bengal Children Act—1959

List of Bal Sevika Training Centres in India*

(Under the Indian Council for Child Welfare)

Sr. No.	Name of the State	Name of the Place
1.	Andhra Pradesh	Hyderabad
2.	Bihar	Patna
3.	Gujarat	Junagarh
4.	Delhi	Delhi
5.	Kerala	Trivendrum
6.	Maharashtra	1. Kosbad 2. Hingane
7.	Madhya Pradesh	Indore
8.	Mysore	Bangalore
9.	Punjab	Chandigarh
10.	Rajasthan	Jaipur
11.	Tamil Nadu	Madras
12.	Uttar Pradesh	Lucknow
13.	West Bengal	Calcutta
14.	Manipur	Imphal

* Sourcebook for Pre-school Education, Indian Association for Pre-School Education, Baroda, 1972, p 71.

List of Family and Child Welfare Training Centres in India Run by the Central Social Welfare Board*

Sr. No.	Name and Address of the Training Centre	Name of the State
1.	Family and Child Welfare Training Centre, P. O. Gandhigram, Distt. Madurai.	Tamil Nadu
2.	Family and Child Welfare Training Centre, Sri V. T. K. Institute of Rural Development, M. S. University of Baroda, At & Post Samiala, Distt. Baroda.	Gujarat
3.	Visva Bharati Family and Child Welfare Training Centre, Sriniketan, P. O. Sriniketan, Distt. Birbhum.	West Bengal
4.	Family and Child Welfare Training Centre, K. G. N. M. Trust, P. O. Kasturbagram, Indore.	Madhya Pradesh
5.	Family and Child Welfare Training Centre, Allahabad Agricultural Institute, P. O. Agricultural Institute, Allahabad.	Uttar Pradesh
6.	Family and Child Welfare Training Centre, Jamia School of Social Work, New Delhi.	New Delhi

* Sourcebook for Pre-School Education, *op. cit.*, p. 72.

Printed at Delhi University Press,
by S. J. Dubey, Press Manager